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БИОМЕДИЦИНСКАЯ ЭТИКА И КОММУНИКАЦИИ В ЗДРАВООХРАНЕНИИ

BIOMEDICAL ETHICS AND COMMUNICATIONS IN HEALTH SERVICE

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Пособие предназначено для студентов 1-го курса факультета подготовки иностранных граждан высших медицинских учреждений образования, изучающих биомедицинскую этику и коммуникации в здравоохранении на английском языке.

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FOREWORD

Biomedical ethics and communication in health service system is an academic discipline containing systematized scientific knowledge of the theoretical principles and organizational principles of biomedical ethics and communication in healthcare.

The **purpose** of the teaching and learning of the discipline is a formation of students' moral values, conscious moral attitude to life, health and a person's death, as well as communication skills, develop strategies of interaction with patients, the public, health professionals.

Tasks of the teaching of the discipline "Biomedical Ethics and Communication in Health Service" consists in the acquisition of academic competencies the students which are based on knowledge of:

- ethical, legal framework and aspects of medical practice;
- moral sides of the actual problems of modern medicine and biomedical research;
- the basic principles and problems of biomedical ethics;
- the foundations and principles of communication with patients and health service professionals;
- methods and tools for shaping public opinion, aiming at health preservation.

I. BIOMEDICAL ETHICS IN HEALTH SERVICE

1. BIOMEDICAL ETHICS: ESSENCE, BASIC PRINCIPLES

1.1. Features of the professional activities of doctor. Availability of professional ethics as a necessary factor in the regulation of medical activity. Historical stages of development of medical ethics.

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1.1. Features of the professional activities of doctor. Availability of professional ethics as a necessary factor in the regulation of medical activity. Historical stages of development of medical ethics

Features of any subculture determined *lifestyle, activities, interests, characteristic of the group* is a carrier of a particular subculture. Therefore, to identify the specifics of the medical subculture is necessary to identify the features of the professional activity of the doctor. They are defined primarily object, character of the object and its activity. **The object** of professional work of the doctor is a **man**. However, a person is an object of study and exposure to many sciences (anthropology, education, psychology, etc.). The medicine differs from them in *complex and multifaceted subject of its research*: in the center of its focus is *health and human disease*, the identification of normal and pathological condition of a person. The feature of medical practice consists in the fact that the sick person, being an object of study and medical effects, is at the same time the *subject* of the treatment process, taking active part in it. Firstly, the patient does not worry whom he trusts his health: he carefully evaluates the doctor, tries to find in him not only a good specialist, but also a sympathetic person. The patients are more receptive to the treatment, if they see that their doctor realizes the problem and heals the person, not the disease. Secondly, as the subject of the treatment process the patient may contribute to or, conversely, to prevent the success of treatment: your attitude, mood, optimism or pessimism, the level of trust or confidence to the doctor's recommendations, etc.

The features of the professional activities of doctor determined main ***purpose***, which *serve the preservation of human life and health, prevention of diseases and alleviate the suffering of patients,* regardless of their gender, age, race, nationality, social status, political views and religion.

The feature of medical practice is the fact that it has a distinct spiritual value component that is difficult to find, say, in the work of an

engineer or an agronomist. This feature of the medical and pharmaceutical activity necessarily implies the existence of strict rules of professional conduct, because in these areas there is a risk of harm to life and health of the patient. In this regard, the activities of physicians and pharmacists is based on block-based universal moral values.

The medical profession requires an organic combination of humanism and high moral qualities and deep professional knowledge. Thus, the distinguishing feature of medical subculture is that before the beginning of its activity the future doctors give oath of the doctor after the graduation of the university. This is of great symbolic and social significance: the moral principles of man's relationship to a man become mandatory statutory rules of behavior of a specialist. Summary of specific commitments collected oath distinguished professional, medical specialists from other disciplines.

There are the following stages of the development of medical ethics.

Medical ethics as a part of medicine exists and develops more than one millennium.

Phase I *development of medical ethics* – II *thousand BC* (Neolithic) – *V-IV century BC* (Hippocratic Oath). During the Neolithic (New Stone Age, approx. 8-3 thousand BC) there is the system of scientific knowledge, which later would be called medicine. At the same time the first stage of development of the science of human behavior regulation starts who owns the art of healing, that is medical ethics. The most ancient source, where the requirements to the doctor and his or her rights, are considered to belong to the 18th century BC. *"Code of Hammurapi"*, adopted in Babylon. Issues of medical ethics are reflected in the monuments of ancient Indian literature – in the "*Code of Laws of Manu*" (about 2 BC – 1 BC) and in the "*Ayurveda*" (Life Sciences; 9-3 centuries BC.).

There are three editions of "Ayurveda" – this medical encyclopedia of antiquity. It belongs to the physician Sushruta. In one of the books "Ayurveda" states what should be a doctor, how he should behave, how and what to say to the patient. Noteworthy is a differentiated approach to the patient: it is possible and necessary to treat the poor, orphans, foreigners, but at the same time it is impossible to prescribe medication to those in favor with the Raja. With the advent of social inequality ratio of patients to doctors becomes ambiguous: the representatives of the ruling classes saw them as servants, and the oppressed classes – masters.

An invaluable role in the development of the principles of medical ethics was played by *Hippocrates* (460-377 years BC. E.). He is called the *"father of medicine"*, as it codified pre-existing in ancient times disparate ethical aspects of medical practice in a single professional medical ethics. These moral principles of medicine Hippocrates stated in the *"Oath"*, as well as in the books *"The Law"*, *"The doctors"* and others. Hippocrates was the first who drew attention to the issues of physician relations due to the

relatives of the patient, to their teachers, the relationship between doctors. The basic principle in the "Hippocratic model of medical ethics is the rule of "*do not harm* ".

Phase II – Model of Paracelsus and the principle of "do good."

The second historical form of medical ethics is the understanding the relationship of doctor and patient that had developed in the Middle Ages. To express this model is particularly well-managed *Paracelsus* (1493-1541).

"*Model of Paracelsus*" is a form of medical ethics in which moral relationship with the patient is understood as a component of the therapeutic strategy of physician behavior. If the Hippocratic medical ethics model of social trust is won by the patient's personality, the "model of Paracelsus" **–** is keeping *the emotional and mental features of the person, the recognition of the depth of its soul and spiritual contact with the doctor and the inclusion of these contacts in the healing process*. The basic moral principle, emerging within the boundaries of this model is the principle of "***do good," the good, or to "create love," kindness, mercy***. *Healingn* **–** *is organized by the implementation of good.*

An important stage in the development of medical ethics is a creation of the medical faculties at the universities and the union of doctors in the corporation.

In the X century the Medical School of Salerno began to form, which flourished in the 12th century, translated medical books from Arabic into Latin. It has been a secular school, and not the church. Its main achievement is to create a new medical literature. The course included 3 years of philosophy, 5 years of medicine, 1 year of practice, then examination after that the license was obtained. It was the first faculty of the East. After it universities began to open in Europe.

The creation of medical faculties at universities and medical association in the corporation can be considered the end of the second and beginning of the third stage of medical ethics development.

The next stage of the development of medical ethics – deontological.

Deontology (from Greek words «deontos» **–** granted and «logos» **–** science, teaching) **–** ethics section, which deals with debt problems and moral requirements. The term "deontology" was introduced by the English philosopher *Jeremy Bentham (1748–1832),* who used it to refer to the doctrine of morality in general.

From the standpoint of medical ethics the greatest interest of deontological theory of German philosopher *Immanuel Kant* (1724–1804), which he called **–** "categorical imperative" "Act so that the maxim of your will at any time can become a principle of universal legislation".

I. Kant voiced in his categorical imperative "golden rule" generally accepted in the name of ethics of the biblical commandment: "In everything,

do to others should do to you, do you also to them". And although so far retained their importance, many rules and requirements that apply to physicians in the Hippocratic era and the Renaissance to the *70th years of XX century began a new phase of development of medical ethics–**Bioethics*****.**

1.2. Becoming and the formation of bioethics and biomedical ethics. Bioethics, biomedical and medical ethics: the status and content

Modern medicine, biology, genetics and related biomedical technologies have approached the problem of forecasting and management of heredity, the problem of life and death of the body, to control the functions of the human body at the tissue, cellular and sub cellular level. Therefore, more than ever there is a question of rights and freedoms of the patient as a person, respect for patients' rights (the right to choose, the right to information, etc.) The responsibility of the Ethics Committees, which are actually made public bioethics institute.

The main reasons for the emergence of bioethics in the twentieth century:

- *mechanization of modern medicine, the emergence of new technologies in it;*
- *the need for experiments on human beings;*
- *the commercialization of medicine;*
- *the growth of democratic movements for the rights of different social groups (including patient rights).*

Bioethics – an interdisciplinary field of knowledge covering a wide range of philosophical and ethical issues arising from the rapid development of medical and biological sciences and the use of high-tech health service.

Bioethics includes a tissue biology, medicine, philosophy, law (the documents of international organizations).

Bioethics focuses on the study of living beings (not only humans) regardless of whether the application of these studies in human medicine, to care about the rights of the BIOS. It examines the nature of the problem of values inherent in all activities associated with the Living. The subject of bioethics and the highest moral value of acts morally understands the attitude to life and any living, but the main principle – reverence for life.

The main features of bioethics:

1. *The universality and globality*. Bioethics beyond the scope of human life and health, problems relating to the existence of animals and plants, animal experimentation issues, compliance with environmental requirements; because it is equally important for biologists, doctors, environmentalists and related professions.

2. *Normative*. Bioethics aims at developing common or similar regulatory standards; it was concerned that the development of a universal

framework that is defined by common moral principles and therefore requires no "Private", "single", and a single, preferably legislatively fixed solutions; bioethical problem (as opposed to the narrower professional medical ethics) is the rule-making, ethical rationalization, discussing different moral practices which may not be narrowly professional, because not related to the medical profession itself, but in relation to which society arise specialized moral requirements and rules governing the practical relations.

3. *Publicity*: its problems arise in the public areas of life, in the areas of institutional behavior, where actions are conscious and socially significant character (for example, medical ethics is more typical of the "closed", corporatism). Bioethics includes a wide range of social issues related to public health, occupational health and safety, control of demographic processes. It is focused on decision-making and ethical evaluation of practical actions, which actually built the organization of medical practice and the health service system.

4. *Individually–personal orientation*, which is manifested in the authorization of moral behavior - both physician and patient, the ability to select from a variety of behavioral strategies in relation to human health and life – one right; In other words, the main feature of bioethics as a personal-ethical paradigm is determined, first of all, the principle of autonomy.

5. The close relationship with *biomedical ethics, bioethics and medical ethics*: being wider, it embraces them and extends beyond them.

Bioethics is closely connected with medical ethics, but not identical to it. *Medical Ethics* considers mainly the issues arising in the practice of medicine, *bioethics*– a broader concept covering problems of conduct that have arisen in connection with the development of biological sciences in general. Bioethics covers a very wide range of questions – medical ethics, the ethics of science and technology, space research ethics, ethics, environmental studies and more.

Biomedical Ethics (BME) is interdisciplinary research field that combines medical and biological knowledge and human values; *this systematic study of human behavior in the light of moral values and principles within the life sciences and health*. ***The subject of BME*** stands moral attitude of society in general and professionals (doctors and biologists) to the man, his life, health, death – in the course of treatment, and in the course of ongoing investigations with his participation. In the foreground, it puts forward the task of protecting, maintaining and strengthening its life and health. It is integrative in nature, concentrating and combining the common bioethical issues and requirements from a purely medical – specific situations and incidents, turning them into a precedent, becoming the basis for ethical generalizations, conclusions and subsequent recommendations.

Medical ethics is a relatively self-contained complex in biomedical ethics, consisting of two interconnected parts:

- *medical axiology* (the study of professional values);

- *medical deontology* (the study of proper behavior in the exercise of professional activity).

Medical ethics a professional ethics, which includes the traditional installation of medical ethics, but today is not limited thereto, and rises in a new environment with a new level of understanding of the ethical issues that arise in the course of medical procedures, and regulate essentially "human relations" in medicine vertical ("doctor–patient") and horizontal ("doctor–doctor"), although it is not alien to its "open" issues (for example, the problem of choosing a doctor of conduct and decision-making has always existed and has never been unambiguous).

In this wider BME traditional medical ethics, since it includes a range of issues beyond the scope of the latter, for example, transplantation issues, suicide, psychic "norm", and pathology and a number of other "open" issues. In addition, it solves the issues are not corporate, not only within medicine, but on a broader scientific and social basis, on the one hand, acts as an integral part of biomedical ethics, and on the other – is practically a professional ethics.

Thus, each of the examined species of Ethics has its own specificity, which does not allow to identify them. However, for all their differences and specifics of bioethics and biomedical ethics in its aims, objectives and challenges are so close to each other and complement each other, it makes sense to treat them in the same context. They are "open" problems not only match, but also affect each of us (each had to be patient and make decisions regarding life and health of loved ones), and therefore depend on the solutions, not only professionals, but also of society.

1.3. Conceptual model and the problem field of biomedical ethics

Conceptual model of biomedical ethics includes the following aspects:

• *normative*, in which we study the specificity and the "performance" of universal moral values in medicine;

• *situational rationale for moral choice* and decision-making in a variety of biomedical situations and special cases;

• *experimental*, involving the spread of moral principles to biomedical research and ethical review;

• *deontological governing the functions and principles* of conduct in the medical vertical relationship (in the "doctor-patient" system) and horizontally (in the "doctor-doctor" system);

• *institutional*, related to the need to address social and occupational health issues and the role of bioethics committees as a special institution in the process.

The definition of these aspects allows to outline the contours of the problem field, and identify the range of legal and ethical issues, which, on the one hand, bioethics and biomedical ethics are called to engage in science and who, on the other hand, should be of particular concern in the formation of moral attitudes of health professionals. Moreover, it revealed not one but several "circles" issues which are intertwined and mutually complementing each other, determine the content of BME.

The main problem BME communities are as follows:

• modification of traditional moral principles and values in professional work of medical professionals and biologists – *legal and ethical terms*;

• moral conflicts in specific situations – incidents arising in the course of biomedical research and treatment of patients – *a situational approach*;

• «new» interpersonal relationships in a system of vertical and horizontal linkages in the field of modern medicine – *deontological circle*.

The first round of bioethical issues – legal and ethical – is the need to trace how can and should manifest itself in medical practice and biological research – on the theoretical and practical levels – universal moral values and principles, how to handle them the standards of conduct of the doctor and researcher, speaking foundation "strategy and tactics" of their professional choice.

1.4. Universal principles and norms of biomedical ethics

Socio-humanistic expectations of society, on the one hand, and the urgent requirements of practical medicine and biology, on the other, make it necessary treatment of biomedical ethics to consider universal ethical principles, based on which are produced by specific moral norms of behavior of the doctor and medical researcher, and which should be based on provide the basis for population health system.

The international community and the scientific and medical community is constantly working in this direction. Ethical principles of biomedical research are identified and justified in the *Nuremberg Code* (1947), *the Declaration of Helsinki* (1964), *the Council of Europe Convention "On Human Rights in Biomedicine"* (1996) and their *Additional Protocols* (2005), the *UNESCO Universal Declaration on Bioethics and Human Rights* (2006) and others.

The Helsinki Declaration includes a number of basic principles such as the principle of autonomy of the individual, informed consent and confidentiality. The "classical" principles of bioethics, proposed by *T. Beauchamp and J. Childres* (USA) – the so-called "Georgetown mantra" – also include *respect for individual autonomy, justice, doing no evil, for the benefit of the orientation (do good).* For a long time a priority in the development of the United States belonged to the principles of bioethics.

Basic ethical principles of European bioethics and biolaw developed in the framework of the research project of the European Commission – "*principles of Kemp*" (named after P. Kemp – author and coordinator of conceptual ideas) – formed the basis of the Council of Europe Convention "*On Human Rights in Biomedicine*" and in as fundamental include autonomy, dignity, integrity and vulnerability of the human. Within the framework of bioethics these principles are called universal, because they are universal mandatory, and applies to all aspects of community and biomedical ethics. These primarily include ***respect for individual autonomy (its right to self-determination)*** and the desire to ensure the good of the patient, based on fundamental democratic values – ***solidarity, complicity, compassion, the idea communication interests*** (B. Jennings). Even a simple enumeration shows that the first place among the universal bioethical principles is the principle of individual autonomy. As for other principles that they act in a different "set" and sometimes carry different content, reflecting the specificity of the regional campaigns for human rights, national traditions and values.

The autonomy of the individual – the principle of BME, based on the unity and equality of rights of the doctor and the patient, suggesting their mutual dialogue, in which the choice and responsibility is not focused entirely in the hands of doctor, and shared between them and the patient. According to this principle, the adoption of reliable ethically medical decision based on mutual respect for the doctor and the patient and their active co-participation in the process, requiring competence, patient awareness and voluntary acceptance of the solutions.

Informed consent – the principle of BME, is required to obtain the consent of the patient or subject to any interference in the sphere of health (hospitalization, treatment or research assignment). It requires compliance with the patient's right to know the truth about the state of health of the existing methods of treatment of the illness and the risk associated with each of them.

Voluntary – another principle BME related to patient autonomy. It is respect for freedom of expression of the person, which involves an independent decision-making, or consent to medical procedures or research with the knowledge and the lack of external coercion – not only physical or moral pressure, but depending of any kind, i.e. it should be received no threats, violence and deception. Voluntary consent – it is the right of patients to obtain such consent, the patient – it is the doctor's duty.

Integrity – BME principle that indicates the identity of the person itself, its identity, prevents damaging manipulation with it (in particular during Biomedical Research). Integrity involves both physical and mental side of the individual's life, it is associated with the "life story" of the individual, which is created by the memory of the most important events of

his own life and the interpretation of life experience. In other words, the integrity of the individual – is its uniqueness, individuality and originality.

The vulnerability of BME as a principle should be understood in two ways: Firstly, as a characteristic of all living beings (not only human), each individual life, by its very nature finite and fragile. In this sense, the vulnerability as the common characteristic of life may have a broader meaning than bioethics: it can also be determined by social and/or moral alienation of people in society.

To some extent, all the progress in the field of medicine and biology can be considered as the fight against human vulnerability, the desire to minimize or "push" it. This vulnerability – including mortality and finiteness – optimistically regarded as a certain fact which can and must be overcome. However, there is a danger of depriving a person experiences pain and suffering, which is very significant in our perception of reality.

The second understanding of vulnerability – more narrow – refers to certain human groups and populations. Vulnerable subjects – persons whose voluntary consent to participate, for example, in a clinical trial may be the result of excessive interest associated with grounded or ungrounded ideas about the advantages of participation in the study or, on the contrary, sanctions by the higher facing courts in case of refusal to participate. These include representatives of the slave unit in medicine (for students of higher and secondary medical, pharmaceutical and dental schools, clinics and laboratories, staff, employees of pharmaceutical companies). Vulnerable subjects also include patients with incurable diseases; persons held in the homes of the elderly and disabled; patients in emergency situations; Representatives of national and other minorities; unemployed, homeless, low-income citizens, tramps, refugees, children, and members of the armed forces and prisoners.

Vulnerable groups need special care, responsibility, fairness to him – a weak and dependent.

Justice, under the humanistic bioethical paradigm – this is the principle, assuming the implementation of social programs, according to which the equal access of all segments of the population to public services, including the preparation of biomedical services, the availability of pharmacological agents necessary to maintain health, the protection in biomedical research of the most vulnerable segments of the population. According to the principle of justice, the benefit to the patient must always be greater than the scientific or public interest. This principle is closely linked to the principle of tolerance.

Tolerance – the universal moral principle, which means tolerance of different views, opinions, norms of behavior, communication and activities other than those which are followed by society; It suggests endurance, self-control, the ability to mutual understanding and harmonization of diverse

interests. The BME tolerance principle implies concern for the preservation of human life and health, prevention of diseases and alleviate the suffering of patients, regardless of gender, age, race, nationality, social and material status, political views and religion. The principle of tolerance also ensures respect for the assessment and the opinion of colleagues in clinical research or manipulation.

***Privacy* –** the principle of BME, providing mutual trust between doctor and patient. Confidentiality requires strict adherence to medical confidentiality, safe custody of physician information provided by the patient, the anonymity of the research, to minimize interference with the private life of the patient, careful storage and restriction of access to them not only in life but also after the death of the patient. The confidentiality principle manifest devotion to the doctor the patient's interests, his professional honesty and integrity. Storing confidential information concerning the patient is determined by the right of every person to respect for his private sphere of interests.

1.5. Background Documents on Medical Ethics of the World Health Organization, the World Medical Association

One of the first systematized codes of laws was *"The Hippocratic Oath"* (V century BC).

Ethics of healing until the middle XX century, developed by physicians in each country for itself (eg, *"Geneva Declaration of Physicians" (1848*). Since 1946, after the creation of the World Health Organization (WHO) within the United Nations, these questions were developed its units (the World Medical Association (WMA), UNESCO and its substructures, the International Bioethics Committee, the Intergovernmental Bioethics Committee, etc. as a recommendation for all countries of the world in general by the 60-70-th years of XX century, was formed by a series of arches on ethics healing. They were documented medical organizations in the world and in many ways bring closer the positions of various countries on the issue.

"The Nuremberg Code"(1947) is an international document regulating the principles of conducting medical experiments on people. The Code was developed and adopted after the Nuremberg trials of physicians in 1947 and is the basis for many national and international laws.

"The International Code of Medical Ethics" adopted by the 3rd General Assembly of the World Medical Association (London, October 1949) defines the general duties of physicians: the physician must always maintain the highest standards. The doctor must make the decision solely in the interests of the patient. At the heart of the doctor should put the compassion and respect for the human dignity of the patient and fully responsible for all aspects of medical care, regardless of their own professional specialization.

The second half of XX – the beginning XXI century show great attention of international organizations to the formulation of medical ethics and bioethics principles.

"The Helsinki Declaration of the WMA" defines the *"Ethical Principles of Medical Research with Human Attraction*", adopted by the 18th General Assembly of the WMA (Helsinki, Finland, June 1964).

"Tokyo Declaration of Physicians" (1975).

"The Lisbon Declaration on the Rights of the Patient, adopted by the World Medical Association" (Lisbon, September-October 1981) states that the doctor must act in the interests of the patient, respect the patient's autonomy and fair treatment. The patient has the right to receive information about his health, to refuse medical manipulation. The respect for human dignity and patients' rights for inviolability of private life, cultural and moral values in the provision of medical care and medical training is prescribed. The patient has the right to humane care in case of an incurable disease and to provide opportunities for a worthy and least painful withdrawal from life.

The principles of bioethics are set out in the World Health Organization document *"Declaration on the policy on patient rights in Europe adopted by the* World Health Organization *European Consultation on Patient Rights"* (Amsterdam, March 1994) - *"Patients' Rights", "Human Rights and Human Rights in Health Service"»: "... Everyone has the right to respect for his personality, for self-determination, for preserving his physical and mental integrity, and for the safety of his personality; to respect for secrets; have their own moral and cultural values, religious and philosophical beliefs; the right to protect one's own health. "*

"The Universal Declaration on the Human Genome and Human Rights" (11 November 1997).

Council of Europe Convention "On Human Rights in Biomedicine" (1996, Oviedo) and *the Additional Protocols* (2005).

The Twelve Principles for the Provision of Medical Care in any National Health System - determine the principle of choosing a doctor, and for the doctor - the choice of the patient, without prejudice to each other's rights"... an indispensable professional and ethical duty of the doctor is to provide any person with emergency medical care without any exceptions".

"UNESCO Universal Declaration on Bioethics and Human Rights" (2006).

"International Code of Ethics a doctor" and others.

References:

1. Beauchamp, T. Principles of Biomedical Ethics / T. Beauchamp, O. Childress. – N.Y., Oxford, 1989. –90 p.

2. •Mishatkina, T. Universal principles, moral standards and values of biomedical ethics / T. Mishatkina // Bioethics and human expertise: the

problem of genomics, psychology and virtualistics / RAS, IF; holes. Editor F. Maylenova – M., IP RAN, 2008. – p. 27–47.

3. Bioethics / V. Sergeev [et al.]. – M.: GEOTAR – Media, 2013. – 240 p.

4. Global Bioethics in the social dimension: the dictionary-reference book / ed. T. Mishatkina. – Minsk: The Institute of Radiology, 2015. – 196 p., pp. 103–104.

2. PROBLEMS OF BIOMEDICAL ETHICS

2.1. Life is as higher value. Ethical and legal aspects of human reproduction

2.1.1. The phenomenon of life to bioethics position.

2.1.2. The autonomy of an expectant mother and right of an embryo on life. The ethic of problem of an artificial abortion.

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2.1.1. The phenomenon of life to bioethics position

Life and death are fundamental antinomies of human life. Hence, the deep desire to understand the phenomenon of life and death in various angles - philosophical, scientific, cultural, and legal, and are currently in the bioethical perspective, is to investigate the problems of the beginning and end of human life (conception, abortion, euthanasia, etc...).

The problem of *origin of life on the Earth has three versions***–** natural origin of life; bringing of life from Space; creation living. A question about an origin and beginning of human life is a deep and while yet not exposed in full secret.

Why does life have such value for a man*? Firstly, life is the universal necessary condition of realization of all another (real and utopian) aims, tasks, dreamings that a man puts before itself.* Really, in fact in an order successfully to make off an university, become a good specialist, to find family etc., it is foremost needed to "be living", it is needed to live.

Secondly, unlike the animal the man a wares of his mortality understands that life is not endless. Therefore he aims to prolong the life, become familiar with eternal, leave about itself memory. But it succeeds to the man only in case that his life was filled with sense.

Thirdly, coming forward an absolute, higher value, life can have a different price. Naturally, each person strives to add value to their lives in their own eyes and in the eyes of others. For this, he formulates for himself

the purpose of life, poses not only a utilitarian purpose and meaning of life. And as such, they become only when filled with meaning.

In the *naturalistic direction* of ethics of life, oriented on natural sciences and, foremost, biology, life is comprehended as the naturally-historical phenomenon, and ethics is base on idea of fight against death.

It is followed by at least two conclusions. Firstly, that the meaning of life cannot be determined definitively, because it is not set in advance, and the formed a person at each stage of its existence. *Therefore, the meaning of life is life itself, to live an authentic life, be a man under all circumstances, even in spite of them.*

The first place among common to all mankind values is occupied by the values of life and health **–** initial priority values of medical culture. A health is a major life-support value, exactly it comes forward necessary pre-condition of his valuable, harmonious life of man, satisfaction of his material and spiritual necessities. An aim of medicine **–** guard of life and health of people, their maintenance, strengthening, renewal and maintenance, warning and treatment of diseases is does them the higher value of medical activity.

In the framework of *modern bioethics* at research of ethics of life do questions arise: what point the embryo can be considered a living being? Is abortion permissible? Whether to support the life of terminally ill patients? Is it permissible to moral and legal, socio-cultural and religious positions of euthanasia? etc.

In **biomedical terms of life –** a specific form of organization of matter characterized by inherited a program stored in a set of genes (genome), in the corresponding sequences of deoxyribonucleic acid nucleotides (DNA); metabolism, the specificity of which is determined by the genetic program of self-reproduction, and in accordance with this program. A code by means of that the inherited program is written down is universal. All living things use the same scheme for encoding, transport (and translation) of information and biosynthesis. The basis of life is defined and complex genetic program, which is implemented through the exchange of substances.

New approaches in relation to the life brought into medical bioethics activities. *Schweitzer's principle of* ***"reverence for life",*** offers and requires reverence for life always and everywhere, when the individual meets the other manifestations of the will to live.

Universal Declaration of UNESCO on Bioethics and Human Rights (2005) and requires in clinical practice and biomedical research display particular, careful attitude to any form of life. These requirements are particularly relevant in the light of the development of new genetic engineering and biomedical technology, when it comes to the fate of the embryos, stem cells, the experiments in the field of assisted reproductive technologies and intervention in human nature.

The ethical-philosophical concept of the phenomenon of life has become a moral vector relationship of man to life, in general, to peace, to the environment, thereby creating the prerequisites for understanding moral conflicts and choices facing contemporary bioethics. The context specified philosophical reflection on the ethical foundations of life, considering life as the higher value, is reflected in international and national instruments promoting the ethical-legal regulation adopted in medical practice solutions. So, the **Geneva Declaration of physicians (1848)** says: "*I will maintain the highest respect for human life from the moment of its conception; even under threat I don't use my knowledge in the field of medicine contrary to the laws of the brow of eternity*". The **Helsinki-Tokyo Declaration of doctors (1964, 1975)** for conducting biomedical research involving humans indicates that: "the Mission of the physician to safeguard the health of people. The knowledge of the doctor and his conscience serve you to implement that mission." Art. 2 of the **Code of medical ethics adopted by I Congress of doctors of the Republic of Belarus (1998),** approved by the Ministry of health of Belarus (1999) States: "the Main purpose of professional activity of the doctor is to save life and health, preventing diseases and alleviating the suffering of patients regardless of gender, age, race, nationality, social and material status, political beliefs and religion".

Bioethical basis of research of the phenomenon of life associated with the problems of the status of start and end of the nascent human life, its artificial conception, prenatal diagnostics, development of contraception, sterilization of women, abortions, and others.

2.1.2. Autonomy of an expectant mother and right of an embryo on life. Ethic of problem of artificial abortion

The abortion is one of the oldest problems of medical ethics and philosophy, law and theology. The Hippocratic Oath prohibits medical abortion ("I .... Will not give a woman an abortive remedy"). At the same time, Aristotle drew attention to two aspects of the problem: the need for abortion is justified in his demographic purposes (birth control); at the same time he considered abortion acceptable, while in the embryo not have formed the "sensitivity" and physical activity.

In recent decades, the moral and ethical aspects of abortion has become one of the main problems of the theory of morality. In the discussion of the problems need to answer *three fundamental questions*: 1) Since when the living entity begins to admit a person possessing a certain set of rights, primarily the right to life? 2) Does the case of restriction of the commandment "Do not kill"? If "yes", what are the reasons? 3) What is the moral and social status of those living things that are not yet recognized as a human?

One of the problems that interests biomedical ethics – a *problem of the origin of human life*. The question of at what point the pregnancy we can speak of the existence of the fetus as a person worries scientists.

When ethical issues relating to physician relationship to an adult patient, in most cases there is no need to discuss the issue of human values, because the answer is obvious. However, when it comes to the protection of human life before birth, especially if the value of the unborn person would relate to the usual value of already born, such issues are more complex. Is the embryo or germ of a complete human being, whether he needs the same level of protection? What is the moral status of an unborn human? When, at what time, at what point in the pregnancy process, the embryo becomes a human being, with all the rights inherent to man? At the moment of conception? In the first third, second or third stage of pregnancy? At the moment of birth? And this is not a medical and ethical issue – the question of the moral status of the human fetus. Depending on the response and can only be resolved the issue of the resolution and the prohibition of abortion.

Thus, today, it needs to be worked out criteria for determining the moral fetal status, and this criterion should be general enough so as not to conflict with other moral criteria, and so broad that could also apply to other living beings, not just to the fetus and the fetus human .

The beginning of human life is generally considered to be the moment when the newborn, in the figurative expression, "see the light". In fact, human life begins 40 weeks before, but the first 40 weeks of his life a person spends in the mother's body. It is necessary to understand what the criterion for determining the human life. The answer to this question can be given from different perspectives: *religious, philosophical or biological*.

From a *religious point of view*, the beginning of human life is the moment of the creation of the soul. However, the views of believers of different faiths on this subject differ. If there is a plurality of religious trends and the existing freedom of religion it is difficult to give a clear universal religious concept of such a complex category, as "the beginning of human life." The difficulty also lies in the fact that there are people who do not believe in the existence of the soul.

Philosophy operates a variety of definitions and concepts. Many philosophers, for example, believe that "something" until then will human life, until it reaches a certain level of consciousness, a certain capacity to love our neighbor, a certain degree of humanity or the level of culture, a certain degree of independence and vitality, a certain measure of physical or spiritual perfection etc.

The biological definition. Any discussion of human life must first access the data of embryology, fetology and medicine.

The term "embryo" is usually called a fertilized egg up to eight weeks of pregnancy. If in the beginning of embryonic development adopted the time

of formation of the zygote, the first few days after fertilization, cell division to form a group of identical cells, in addition, later formed blastocysts have not yet attached to the uterine wall, which allows some modern experts speak not of the embryo, but the preembryo. At this stage, most of the cells is neither structured nor individually defined entity, but rather a source of growth of the placenta, and therefore cannot be regarded as actual embryo. *Around the 14th day of the primitive streak appears, after which the nervous system is formed*. This was the basis for a position entered in the legislation of many countries ***that the border 14 days there last time, when possible to conduct research on human embryos***.

There is no single point of view approaches include natural sciences. ***One position – this is the beginning of formation of neural tissue in four weeks***. But among physicians and embryologists, there is another position - human appearance in the case ***where the formed pulmonary system – the twenty-second week***. Unity in these positions there. Representatives of different embryological schools still cannot decide what to take as a starting point, the beginning of human life.

Further, the opinions of different authors begin to diverge, it is often said that under the status the embryo is a person (supporters of the "preservation of life"), while others (supporters of "free choice"), that it is only potential and not a real person until birth.

The ethical position says that human life and the identity exists when a human being is the subject of moral relations. Therefore, from the standpoint of ethics and from the point of view of the Christian religion, human life begins at conception.

Complex moral debates today are on the *abortion issue*, identifying with the *three main positions for the understanding of the issue*: ***the liberal, moderate and conservative.***

The issue of abortion **–** it's part of the issue of reproductive health and reproductive rights. The most important of these rights is considered to be available to men and women of all modern means and methods of family planning. Woman gives birth to the children, which corresponds to the conditions and situations in which it is located.

As said one of the first activists of the movement for women's rights to abortion A. Davis: "Whatever the rights granted to women or **–** to vote, receive education, etc. All this is worthless if you do not have the right to dispose of their own bodies and to control what happens to him when our fate can change those from whom we can get pregnant due to accident, deception or use of force ", i.e. ***Abortion proponents claim a woman's right to control her own body, because fetus, embryo is part of the body, and therefore the woman alone decides his fate***.

Another reason follows from the first **–***the negation of the personal status of the fetus*.

Abortion for medical reasons is ethically justified, since preferable to save the life of a woman, rather than save the fetus.

According to the ***liberal position*** until the moment of natural birth a *woman has the full right to decide to perform an abortion*, and the doctor is obliged to ensure the realization of this right. *Unborn fetus is not recognized in any sense of the human person, on the unborn fetus is not covered by the right to life.*

The arguments that lead ***opponents of abortion are numerous and quite convincing***:

1) The effects of abortion are genuine social evil. Every year in the world die 70 thousand women from abortion complications. According to the World Health Organization's 1000 women accounted for 30 unsafe abortions.

2) The *human fetus has the same right to life, as it does every man* **–** the recognition of the personal status of the fetus. Traditionally the main issue in this problem - it is a question of the viability of the fetus.

3) A special theme **–** whether the fetus feels pain. If you feel, so alive, and abortion is murder.

For ***moderate position*** is characterized by the idea that the conversion of natural substance in the human personality is carried out gradually in the process of development from conception to birth. The fruit in the process of how to accumulate the amount of their humanity and, therefore, the volume of the right to life. If pregnancy is divided into three equal parts (each part of three months duration is called the term), the first three months of the scope of rights of the fetus is minimal and may exceed the social and economic interests of the mother. In the last trimester it is already very significant, and moderate positions may exceed the interests of the mother of the fetus the right to life only when there is a direct threat to her life.

The decision on the legality of abortion is the most difficult in the second trimester. There is less consensus of all and most of all the possible options for logical reasoning or moral rights weighing both mother and fetus. Since the fetus has a certain amount of human rights, abortion, from this point of view, it can be classified as murder the innocent. Naturally, there is a situation that requires to offer arguments to justify the murder in an innocent case. Status aborted fetuses moderate interpretation of the authors consider as an intermediate between the human and the animal, which implies the need for a special ethical and legal standards governing the use (recycling) these creatures.

According ***to conservatives***, the *abortion cannot have moral justification. The abortion is considered as direct murder*. The embryo from the moment of conception - is a person, which must be attributed to the bulk of human rights - especially the right to life.

There are ***ultra-conservative stance***, banning the abortion within the overall conservative understanding. Supporters of moderate conservatism

recognize the right to abortion in the presence of a direct threat to the woman's life or in cases where the pregnancy is the result of rape or incest. The basis of conservative views tend to favor a religious position. In any case, the abortion is a grave moral and physical trauma for a woman harming her health and interrupting the life of the unborn person.

2.1.3. The ethical dimension of control underreproduction. Moral problems of contraception

In the 70-s XX century with the advent of a method of diagnosing the status of the fetus in the womb, t. e. to determine the presence of defects, abnormalities, genetic diseases, bioethics, a new important section. The part of this diagnosis is ultrasonography (USG) – an ethically acceptable way to diagnose and amnitcentesis – a method of representing a danger to the fetus, but is used in case of danger of physical or genetic fetal defects. Currently not found a way to medical or surgical treatment of the fetus in the womb. At the present moment doctors have the task to abort such embryo on the early stage of its development. This raises a moral dilemma for parents, since the adoption of such a diagnosis means accepting the idea of abortion.

Contraception– another important aspect of bioethical debate. The introduction of an intrauterine device (IUD) birth control and their systematic use in underdeveloped countries, are harmful according to the assessment of Jacques Sudo, ethically controversial, not only because these funds in their characteristics are contraceptive abortive, but also due to the fact that in underdeveloped countries the way the installation of these contraceptives is like veterinary, and bears no respect for man.

Contraceptive pill estrogen histogens, Pearl Index of 1 (the number of women out of 100 who can get pregnant per year) were adopted for the liberation of women from unwanted pregnancies. At the same time, they have become a means of deprivation of intercourse his genital focus, a means of achieving a free, no noncommittal sexual relations, and led to the lowest birth rate in the history of mankind. New contraceptives – tablets containing no estrogen implantable or injectable agents in their characteristics are also abortifacient. The spread of abortion, making a definitive conclusion Jacques Sudo, very little to do with the development of medicine and its progress. Controversy over abortion extend far beyond bioethics. However, the bioethical aspects in this area is important, since it is thanks to him that the embryo can be seen as a human being and, therefore, require legal protection for him.

2.1.4. Ethical issues of reproductive technologies

Within the bioethical discourse expressed different points of view and with respect to the artificial conception. The artificial conception or

fertilization in vitro (test tube) revolutionized obstetrics and treatment of female infertility. In 1978, Louise Brown, was born in England – the first child, was born thanks to the method of "fertilization in vitro», proven in animals. Soon Amandine (1982) was born in France after that. In 2009, the number of children who were born in this way, exceeded 14,000.

However, this method, as indicated by medical researcher Jacques Sudo, has the shadow side – and not only because of the use of foreign human sperm (donor) in relation to a married couple, attracting a surrogate mother, but also because of the destruction of human embryos. In order for fertilization was successful, in the woman's uterus introduced several embryos; the others remain in a frozen state. Among introduced embryo in the womb will develop one or two, while others are subject to abortions. Frozen embryos when they are not used, are killed after 5 years of storage. Moreover, today as a material for scientific experiments in vitro fertilization method offers live human embryos.

The practice of reproductive technology associated with the birth of a person, such as artificial insemination with sperm donor or a husband, fertilization outside the body (in vitro), followed by implantation of the embryo in the uterus of women, surrogacy is when the egg of a woman is fertilized in vitro, and then the embryo is implanted to another woman, to carry a fetus for genetic mother confronts bioethics new philosophical and ethical issues. How morally and legally justified sperm donation or egg? Should respected medical secrecy (confidentiality) for artificial insemination of the donor of embryonic material? Do the right to information about their biological parents, children born through the use of a sperm donor? Should the donation of genetic material to be gratuitous, altruistic?

The same kind of ethical and legal conflicts arise in the case of in vitro fertilization, when you have to decide on the moral and legal status of the embryo stage of development of the embryo as a human being, the establishment of maternal child with egg donation (the mother is the woman who gave birth to a child or egg donor).

2.1.5. The problem of surrogate motherhood

The goal, which at all times almost all couples seek is the birth and upbringing of children. For many, giving birth to a child is the most important thing in life, therefore people are ready to do anything for the realization of this idea. However, many couples cannot give birth to their own children. In a number of cases, married couples resort to the services of surrogate mothers, as a result of which there are various kinds of surrogate motherhood problems.

Surrogate motherhood is the fertilization, bearing and birth of a child, which occurs according to a contract concluded between potential future parents and a surrogate mother. At the same time, the sex cells of future

parents are taken for the fertilization of the woman, for whom it is impossible to have a child for medical reasons. A surrogate mother is the woman who agrees to be fertilized by the cells of a man and woman (future parents), to bear, give birth and transfer the child to the hands of legal parents.

The agreement on surrogate motherhood can be commercial and non-commercial (altruistic). The first provides material compensation, the second does not imply any payment, other than reimbursement of expenses during pregnancy. Non-commercial programs are usually performed against relatives, their participants may not meet the general requirements of reproductive legislation. Commercial programs are usually conducted with the help of intermediaries - firms that select surrogate mothers, legal parents, medical institutions.

In vitro fertilization (IVF) is used in world practice in infertility therapy since 1976.

Thesurrogate motherhood, like other types of reproductive technology, in modern times help many couples enjoy the joy of paternity and maternity, have significant shortcomings, and significant advantages.

The problem of surrogate motherhood is not only a social matter, but also a moral, ethical and legal one. The surrogate motherhood as a relatively new institution, developing in the Belarusian society, has both its supporters and opponents.

The social value of the surrogate motherhood in modern society is obvious. For Belarusians in the conditions of aging of the nation, increasing the number of infertile marriages, this institution is called to some extent to relieve the tension of the demographic situation, to ensure the realization of the citizens' right to procreation.

The surrogate motherhood procedure is possible only with the following indications:

- absence of the uterus (congenital or acquired);
- deformation of the cavity or cervix of the uterus in congenital malformations or as a result of diseases;
- synechia (adhesions inside the uterus) of the uterine cavity that can not be treated;
- various diseases of the internal organs, in which pregnancy is contraindicated;
- unsuccessful repeated attempts of in vitro fertilization (IVF) with repeated receipt of high quality embryos, the transfer of which did not lead to the onset of pregnancy.

Surrogate mothers may be women who voluntarily agreed to participate in this program. Requirements for surrogate mothers:

- age from 20 to 35 years;
- having your own healthy child;
- mental and physical health.

The problems that arise in this case are of a contradictory nature:

- children turn into goods that can be sold and bought;

- surrogate motherhood becomes so-called work under the contract, therefore at the woman of thought on earnings will be initial, and reasons of advantage for itself, the kid and associates become minor and as though leave on the second plan. There are situations in which wealthy couples or individual men, women can take in the service of not wealthy women who are ready for the sake of money for everything, even bearing and the birth of children, which is completely contrary to the natural instincts of man;

- supporters of the feminist movement note that surrogate practices will trigger the exploitation of the female half of the population;

- church employees say that surrogate motherhood serves as one of the impulses for departing from the humanistic human beginning and from traditional culture, spiritual and moral side of a person. Even if at the beginning of pregnancy the woman felt that she could give up the child born and born with no problems and special labor, within 9 months a very close and mysterious connection was established between the baby and the woman who carried it. For the birth of a child becomes a real psychological trauma, the transfer of the child to the hands of customers. This is an open ethical problem of surrogate motherhood.

Among the ethical problems associated with the use of surrogate motherhood are:

- mental and physical problems are possible for a surrogate mother and a child who is in the womb;

- violation of the notions of blood relationship and kinship;

- necessary securing the mystery of the origin of the child;

- mental disorders in real potential parents;

- the commercial side of motherhood (use of the organ - the uterus - for profit);

- the problem of buying and selling children.

In the case of surrogate motherhood, the children born are the children of the mother (legally), who endured and gave birth to them, but in different countries the laws may differ. Suppose, the law will leave the right to the child only to biological parents. Then the "mother incubator" will give birth to a child for whom she has no rights. That is, the newborn will be forcibly removed. In case the law leaves the mother the right to refuse the transaction right after the birth, there will be a difficultly solvable conflict with biological parents who will be forced to live the rest of their lives with the idea that their child lives in an unknown place in an unknown family. They will not have the slightest right to it. A surrogate mother who finds herself in such a situation can be understood. To bear a child, to hear how his heart beats, will give birth in torments, and then give ... At that moment, the mother's feeling, the love for this child, as to its own one, wakes up. In any

case, the surrogate mother is in a state of emotional and physiological stress, caused by the taking away of the child. Possible mastitis, breast cancer, reproductive diseases. The potential conflict of interests of biological and surrogate mothers is inherent in the procedure of surrogate motherhood and is insoluble, deadlocked. So far, even in countries where surrogate motherhood is allowed, there is no legal scheme that allows them to settle. It should be borne in mind that even if the parties "dispersed" in peaceful terms, the possibility of claims, proceedings, claims for compensation of damages is not exhausted. Can a surrogate mother sue the clinic if she develops breast cancer? Who will be responsible for the possible damage? There are complex relationships between all sides of the surrogate motherhood process, mothers (there are two of them, as absurd as it sounds), fathers, parents, their families, clinics, individual doctors, etc.? What happens if a sick child is born? What is the relationship and responsibility of all parties in case of breach of contract? If a sick child is born?

It is difficult to imagine a more sophisticated and cruel form of exploitation of a woman than a surrogate motherhood. Formally, this is not slavery, but a voluntary service, nevertheless, there are all signs of violation of the right of both women and children. Possible complications of childbirth, inability to breastfeed, body wear, loss of health, emotional shock, risk to life, all this is a fee for a dubious "earnings". In surrogate motherhood, the rights of a woman - a surrogate mother - are violated for money and voluntarily, but this fact does not compensate for her possible losses, damage to the person and freedom.

Since the surrogate motherhood itself is a modified technology of IVF, more precisely, its special case, the ethical problems of IVF remain relevant for the surrogate motherhood. First of all, this is the problem of "*extra embryos*" and the possibility of their destruction, sale, abuse, and a number of others, which have already been the subject of discussion for several decades and, it must be said, they have not been resolved.

Recently, the question of incest, which can be provoked by IVF, suddenly arose. Thanks to IVF, one male donor can have hundreds of children. Theoretically, the number of potential children from one donor may exceed the entire population of the earth. In practice, indeed, one father has hundreds of children, and legally they are not his offspring. Moreover, these children - brothers and sisters - do not know about their mutual relationship. If at the beginning of the spread of IVF there were only one, now there are thousands. The probability of meeting and marriage is far from zero, and in the second generation it becomes even more probable. In this case, no one bears any responsibility for the possible consequences, and they can be very serious.

Commercialization of childbearing. No matter what words about the high value of motherhood is not covered up by the new technology of the

surrogate motherhood, it remains a commercial service, that is, a service that turns out for money and for money. With the development of this technology, the mechanisms of market regulation under the "money-commodity-money" scheme are included. A commodity is a set of services and the child itself. In this process, human life and man himself becomes the subject of trade, acquires the properties of the commodity. Demand creates supply.

Another major ethical question: hide or not hide? No state requires parents who use the surrogate motherhood to tell their children about it. This will be seen as an interference with privacy and a violation of the family's autonomy. The problem with which parents face is that they must decide whether to lie to their child or not. Children always ask questions like "where did I come from?"

Desacralization of motherhood and the destruction of the family. In all cultures, especially European and Christian, motherhood is considered sacred and respect for motherhood is deeply embedded in the moral system of society. No wonder the image of the Mother of God with the Child is one of the most revered. The transformation of motherhood into business, trafficking in children and her body dehumanizes the institution of motherhood.

The Fundamentals of the social concept of the Russian Orthodox Church give a clear description of the concept and practice of the surrogate motherhood as "unnatural and morally unacceptable": "Manipulations associated with the donation of sex cells violate the integrity of the personality and the exclusivity of marriage relations, allowing the invasion of a third party."

The surrogate motherhood exists in a legal vacuum, when it is conducted there are insoluble incidents.

Russia is among the few countries where the surrogate motherhood is legally permitted. The legal aspects of the surrogate motherhood are regulated by the Family Code of the Russian Federation, the Fundamentals of the RF Legislation on the Protection of Health of Citizens. The implementation of the medical component of the surrogate motherhood is regulated by the Order of the Ministry of Health of the Russian Federation.

The concept of the surrogate motherhood is prescribed in the *Code of the Republic of Belarus on Marriage and the Family* (Article 53*). The Resolution of the Council of Ministers of the Republic of Belarus No. 1470 "On Substantial Conditions of the Surrogate Motherhood Contract*" (dated November 4, 2006) established the following essential conditions for surrogate motherhood: the definition of the service provided by the mother's surrogate mother, the indication of the health organization participating in the legal relationships of women, mothers comply with all the prescriptions of the doctor and provide all information about their health status and the state of the child to be born of the genetic mother and her spouse the obligation to

transfer the child after his birth and the period during which the transfer must be made, the place of residence of the surrogate mother, the duty of the genetic mother to take from the surrogate mother of the child and the period during which it must be done, the price of the contract, including the cost of the service bearing and giving birth to a child, expenses for medical care, food, accommodation of a surrogate mother during the period of gestation, childbirth and in the postpartum period, conditions regarding which an agreement was reached upon the request of one of the parties.

Countries where surrogacy and reproductive maternity are legally permitted, including commercial ones: the USA (in most states, although the legislation is very different from state to state), South Africa, Ukraine. Under the new Ukrainian laws, the parents of the child, who was borne by a surrogate mother, automatically recorded his biological parents, the consent of the surrogate mother is not needed here.

Countries where only non-commercial surrogate motherhood is allowed: Australia, Great Britain (surrogate mothers are allowed to pay current expenses), Denmark (with severe restrictions), Israel, Spain, Canada, Netherlands (surrogate motherhood advertising, surrogate mothers' separate states of the USA (New Hampshire, Virginia).

Countries where surrogate motherhood is prohibited by law: Austria, Germany (doctors and mediators, not parents and surrogate mother bear punishment), Norway, Sweden, individual states of the USA (Arizona, Michigan, New Jersey), France.

It is not regulated in any way by law, but there is a surrogate motherhood: Belgium, Greece, Ireland, Finland.

So, the spread of surrogate motherhood has shown a number of contradictions of legal, medical, moral and spiritual nature. The procedure itself is of a doubtful nature, fraught with potential conflicts between participants in the surrogate motherhood process, and they will in fact have a hard-to-resolve nature. The technology of surrogate motherhood, in which large amounts of money revolve, is in deep contradiction with the status and rights of the unborn person.

2.2. Bioethics of death and dying

2.2.1. The problem of death in medical and bioethical dimensions.

2.2.2. The problem of euthanasia in contemporary culture: the pros and cons.

2.2.3. The problem of the relationship of physicians to the dying. Mercy from the standpoint of bioethics. The ethical foundations of modern palliative medicine. Hospice movement.

2.2.4. Ethical-deontological principles in oncology.

2.2.5. Deontological approach to relatives of the patient with malignant neoplasms.

2.2.1. The problem of death in medical and bioethical dimensions

A significant place in contemporary culture takes the phenomenon of death. Death is a natural phenomenon, crowning the end of life. Choosing not to have to man is finite, limited conception of his life and death. The problem of death is one of the main themes of the philosophical, moral, religious and biomedical thinking.

Especially the area under discussion are the issues of death such aspects as the philosophical concept of death, her medical and legal criteria, biochemical processes of aging and dying, the psychology of perception and attitudes towards death, burial rituals, and others.

Death is consistently flowing biological process, change in the human body, rolling from existence to non-existence. Dying man goes through several stages, from the agony to the absolute biological death. Depending on the difference in the stages of dying, their definitions use different names for death: clinical death; death of organs, in particular brain death; biological death.

The peculiarity of clinical death is that pathological changes in all organs and systems are reversible, but only during an insignificant time interval characterizing the stage of the onset of clinical death - 5-6 minutes (sometimes it can be less). This small interval is the interval of life that still lasts. Medical workers in the period of onset of clinical death should actively conduct the patient all the necessary medical procedures. The causes leading to clinical death can be: heavy bleeding, electric trauma, drowning, reflex heart failure, acute poisoning, etc.

In 1968, the Harvard Medical School's special committee published its report on the work, proposing, along with the traditional criterion, the use of a new one - "whole brain death" (neurological criterion) and thus giving doctors the legal right to use the patient's organs in transplantology.

The concept of brain death is based on the conclusions of modern biological science about the theory of the brain as the central integrator of the human body: it is the central nervous system that includes the brain stem that is the controlling center of the living organism; without the work of the central nervous system, a living organism is just a collection of living cells, which does not allow us to speak about the quality of life (since man is not a plant, but a highly organized biosocial unit).

After the death of the brain, which is the organ most sensitive to the arrest of blood circulation, the biological death of other organs and tissues gradually begins. Some of them die relatively quickly (for example, the heart and nights are about 20 minutes), others, on the contrary, can remain viable for several hours, (the blood or cornea of the eye is suitable for transfusion

and transplantation within 6-8 hours after death). Dying of tissues, coming in strict sequence, serves as the basis for determining the time of death. After approximately 24 hours, the tissues of the whole organism are considered to be biologically dead. Biological death is an irreversible cessation of physiological processes in cells and tissues.

The new criterion of "brain death" has become the object of serious controversy and criticism from both medical professionals and ethics, religious representatives, lawyers, and society.

In bioethics, the problem of the death and dying of a person is viewed from the standpoint of modern scientific ideas that death is a state of complete cessation of a person's vital activity. The functioning of all organs and systems of the human body ceases and a state occurs in which no kinds of human activity are possible-neither spiritual, nor psychological, nor social, nor physiological. The entire spiritual and social life of a person is understood as the result of mental activity, and the psyche is a property of highly organized matter - the brain. Death of the brain becomes for the person at the same time death in all other respects. The irreversibility of physiological changes occurring at the time of biological death means the cessation of the existence of a person in a certain qualitative state as a material object - in the fullness of his physiological, psychological, sociocultural, spiritual characteristics as a person, a representative of the terrestrial genus homo sapiens. A person dies as an integral biosocial entity. Death is a natural state that ends the life of a person.

Thus, the traditional understanding of death has undergone a significant transformation in modern culture. The attitude of man to death builds up the entire system of moral relationships. The development of science is increasingly evidence that a person's death cannot be ascertained, remaining within his biological mechanisms of life. So, we need to find a new reference point for its comprehension, to try to understand that death is a process with which a person comes into contact here and now, a process whose beginning does not fit into the usual framework of the biological dimension.

The development of biotechnology, the representation of death as a duration, not only biological, but also social, the multiplicity of death criteria also make it difficult to find a universal answer to a person's question of death. Contemporary disputes on bioethics about death criteria, attempts to highlight the phenomenon of "social death", although for the time being in the field of medicine, only reveal the direction of a new comprehension of one's own being by man.

Criteria of life and death of a person are determined today not only by the results of medical and biological scientific research, but also by the axiological relation to life and death dominating in culture, understanding of the essence and destiny of man, rights and freedoms of the individual. In the

author's opinion, only finding the optimal correspondence between them will allow us to reach a definition of the norms of the doctor's activity when solving these open problems.

2.2.2. The problem of euthanasia in contemporary culture: the pros and cons

Until the middle XX century the question of calling a doctor and medical purposes was obvious: the doctor has to fight with the disease, to maintain the patient's health, alleviate their sufferings and to the extent possible, to prolong his life. Under the new conditions of life extension of the turns are often not relieved, and the extension together with the life and suffering of the patient. This raises the question, the solution of which depends on the prevailing medical culture, values, and that requires a doctor's inner self: Do not turn the noble and humane task medicine the fight against the disease in its opposite the fight for the maintenance of the disease as long as possible.

Therefore, another problem is displayed. Join a pro-contradiction patient's right to life, demanding to save the patient's life by a doctor, and sometimes contrary to his wishes, and the patient's right to moral autonomy – the right to make their own decisions, requiring the physician to respect his deliberate decision, perhaps at the cost of his life.

Today, a great number of philosophical, legal, medical work is dedicated to the human right to death, associated with "borderline situations" of his life. **Euthanasia** (from greek words «ευ» – good + «θάνατος» – death) – the practice of terminating the life of a human or animal suffering from an incurable disease, experiencing unbearable suffering, in meeting requests without medical indications in a painless or minimally painful form, in order to reduce suffering. This term was coined by the English philosopher Fransis Bacon in the XVII century for the definition of "easy death".

There are two types of euthanasia: *passive* (deliberate termination of medical treatment of the patient support) and *active euthanasia* (administration of dying of drugs or other actions which entail a quick death). For active euthanasia is often classified as suicide with medical assistance (providing the patient, at his request drugs that reduce life).

The problem of euthanasia raises important issues such as the acceleration of the death of those who are experiencing severe pain, care for the dying, providing the possibility of a person to die.

The problem of euthanasia gives rise to numerous discussions in which some reject euthanasia as the act of killing, others see it as a panacea for all ills. Euthanasia contradicts the *Hippocratic Oath*: "I swear not to give a lethal drug, even if I am asked to do, or tips that can lead to death." Today, the use of the latest medical tools extends the biological existence of man on

an infinitely long time, turning sometimes unfortunate patient and his family hostage superhumanism.

Christianity, Judaism, Islam oppose euthanasia. At the heart of Christianity is the postulate that life is sacred and inviolable. In it no one has the right to infringe, including neither the doctor nor the man himself. The human right to dispose of his own life and the rejection of non-human, destroying his dignity treatment is the main argument of proponents of active euthanasia. The sanctity of human life, the possibility of medical errors in a hopeless diagnosis, the development of medicine and the likelihood of a cure in the near future those diseases that have not yet treated today, the risk of abuse if euthanasia is legalized, and so on. N. Is a strong argument against active euthanasia. All of these problems indicate that euthanasia – an interdisciplinary problem requiring a permit for their professional and moral efforts of philosophers, doctors, lawyers, clergy, all interested people.

Today more and more people believe that everyone has the right to die, not allowing to prolong life artificially. The decisive argument – the unnecessary suffering of the dying, that doctors cannot alleviate. However, if the realization of the human right to die with dignity is gradually taking root in the culture, the search for ways of its implementation remains difficult bioethical problem that intensive discussion in two ways: as a problem of euthanasia and palliative medicine as a problem, which finds its expression in the establishment of hospices. On the territory of the Republic of Belarus implementing euthanasia, including by means of medical (pharmaceutical) employees are prohibited (Art. 31 of the Law of the Republic of Belarus "On health service").

2.2.3. The problem of the relationship of physicians to the dying. Mercy from the standpoint of bioethics. The ethical foundations of modern palliative medicine. Hospice movement

For many centuries, dying patients occurred in an familiar home environment, and the most difficult period the patient was in a circle of relatives and friends. Their behavior is determined by family traditions, norms of social behavior, religious rites, or relied on intuition and feelings to the patient. Today, an increasing number of patients complete their days in hospitals. This is due to the medicalization of death, development of care for the dying patient, as well as a more conscious and responsible attitude of the modern physician. However, this poses new problems: the relationship to the dying man, rendering him psychological help and support to overcome the accompanying dying painful psychological experiences, contributing to the suffering of the patient.

At the mercy of bioethics understood as compassionate human misery, the desire to help a person to endure pain, loneliness, trouble.

One of the serious ethical problems in the relations between physicians and terminal patients, their relatives – the implementation of the principle of informed consent (to tell the patient the truth about his fatal diagnosis, and prospective patient's reaction to the relatives of the diagnosis). The truth of the patient's bed is a necessary trend of our time, and this applies not only to doctors but also to patients and relatives of all those involved in care.

Changes in personality, its adjustment, resulting from a chronic incurable disease, an altered state of consciousness of the patient often does not allow to tell him the whole truth about the diagnosis and condition. In conversations with the patient is important to consider what the patient really wants to know, and what he fears. This is the benchmark in explaining the essence of the patient's disease to the best of therapeutic measures. Now everything is more frequent dosing recommendations and the available explanations seriously ill or dying of causes and characteristics of his condition. Along with the naming of the diagnosis is recommended to be given in an appropriate form and hope.

Of great importance is the involvement of relatives for emotional support for the patient. The physician should take into account the individual family system and family relations too much family information should be avoided on the state of the patient with simultaneous failure of presentation of such information to the patient.

Questions of palliative care, particularly acute declared themselves in the 70-ies XX century and initiated the creation of special institutions – *hospices*. The concept includes the notion of Hospice Compassionate profound relation of man to the suffering of another person.

Hospice is a medical (medical and social), agency/ department, where a team of professionals providing comprehensive care to a patient who needs to alleviate the suffering – physical, psychosocial and spiritual associated with the disease, cure is not possible, and it must inevitably lead to death in the foreseeable future. Hospice is not just an institution, it is a philosophy at the heart of the cortex is related to the patient as a person until the very last moments of his life with the desire to alleviate their suffering, given his desires and preferences. The patient goes to the hospice to die, and to carry out activities aimed at relief of pain, reduction in shortness of breath or other symptoms with which he and his doctor cannot cope at home. In addition, patients and their relatives at the Hospice provide psychological, social and spiritual support.

Professional comprehensive care provided by the hospice not only to the patient but also his family to accompany the patient throughout the entire period, including special psychological support after the loss of loved ones.

The idea of hospice involves attitude toward death as a natural stage of life, the approach which should be met with dignity. Hospice – the only

place, where the death of a person has the moral sense, about which much has been written Orthodox theologians and modern psychologists. The practice of hospice makes major adjustments in the value orientations of professional ethics of the doctor. Experience hospice denies "white lie" as the custom of ignoring individual approach. The hospice does not impose the truth about the inevitability of imminent death, but at the same time openly discussing this topic with someone who wants it. Patients who do not want to know the truth, have the right and the opportunity to know her.

It can be assumed that hospices will have in the future a positive impact on medicine. Firstly, the accumulation is a special art nursing seriously ill, including dying, to be used by physicians and nurses working with such patients is hospice. Secondly, in this age of highly technical and highly specialized medicine is necessary to rehabilitate the ancient ethical precept of medicine "The blessing of the patient – the supreme law".

2.2.4. Ethical-deontological principles in oncology

Currently, in the world biomedical practice, more attention is paid to bioethics in oncology. The seriousness of the prognosis of the disease, the possibility of relapses and metastases, with seemingly complete cure, oblige for a prolonged and systematic contact of the patient with the doctor, sometimes for life. Communication with an oncological patient without observing bioethical principles is unacceptable. These are such fundamental principles as autonomy, non-harm, benevolence, justice.

The doctor should always act primarily from the position of the foundations of psychology: he must understand that cancer patients are a special category of patients who are on the verge of life and death. If we talk about cancer as of today, then in the psychology of doctors, in the psychology of the population there have been significant changes. Cancer is no longer a fatal disease today. A number of localizations of cancerous tumors, for example, breast cancer, can be cured completely if radical measures are taken in time to remove this tumor.

There are 2 basic principles that determine the tactics of a doctor in relation to an oncological patient:

1) *maximum protection of the patient's psyche*;

2) *every patient with a malignant tumor has the right to treatment*.

When working with patients with malignant neoplasms, the observance of ethical and deontological principles is of particular importance. This is due to the fact that the disease has a particularly strong psychotraumatic effect on the condition of these patients. According to many authors, the prevailing majority of oncological patients revealed signs of obsessive-phobic and asthenodepressive disorders of the psyche. This is manifested by emotional lability, the obsessive fear of death, depression and withdrawal into oneself, the predominance of anxious-hypothetical traits, the

sense of doom, hopelessness due to their disease, the hopelessness of later life, suicidal thoughts. However, in practice, the emotional state of the patient is often not taken into account, especially by young doctors, which undoubtedly aggravates not only the psychological, but also the somatic status of the patient.

Another question of the ethical plan: is it worth telling the patient the whole truth about his illness? One should follow the position: not every patient should know everything about his illness. There are different types of the human nervous system, and if one person in such a difficult situation is ready to mobilize the forces of his body and adjust it to fight the disease, then there are a large number of people who lose all hope at the word "cancer" and consider themselves doomed. And then it is very difficult to bring back such patients to a normal life. But here there is no talk about deception. Just a doctor for his part should inspire such a patient that there is always hope. The conversation must end on "positive" moments, support hope, discuss treatment and plan for further action. It is important to give the patient confidence in receiving them support in the future, in situations that he most fears. For example, if a patient with IV clinical group is afraid of possible pain, you can say: "The situation is not easy, but there are ways to ease your pain" or "Cure is problematic, but we will try to make you feel as comfortable as possible."

From the deontological positions, one should not allow medical documentation and data confirming the diagnosis of malignant neoplasm to fall into the hands of the patient. It is necessary to observe utmost care when talking on the phone about a patient, analyzing X-rays and the results of special studies in the presence of a patient, etc.

Another ethical point that I would like to emphasize is the free basis for rendering assistance to cancer patients, despite the fact that in the diagnosis and treatment of this category of patients, all the advanced achievements of modern medicine and technology are used.

The doctor must constantly improve professionally: constantly be aware of new methods of treatment, diagnosis, must know the advanced technologies used by his colleagues around the world, he must constantly read and improve his professional level.

Despite the evidence for treatment, in some cases, patients refuse it. Often this is due to a complex psychological barrier, which becomes an obstacle to timely special treatment. One can single out the following most common reasons for refusal.

Fear of impending treatment. The patient understands the need for treatment, but the fear of the operation is so great that he does not find the courage to decide on it. The proposal to calm down is ineffective. To eliminate fear, you need to find out its cause. Fear of a patient can be caused by an unsuccessful operation of one of his friends, his own negative

experience of surgical interventions or anesthesia ("I'm afraid not to wake up..."), distrust of the surgeon. In elderly patients, the fear of the outcome of an operation can be caused by concomitant diseases of the heart or other organs.

Only after finding out the cause of fear, the doctor will be able to find a way to calm the patient, instill confidence in the favorable outcome of the operation. It is important to explain that the previous negative experience is the experience of another disease and another operation. For example, you can say: "The cardiologist believes that the heart reserves are high enough," "Pre-operative treatment will reduce the risk of surgery and anesthesia," "Anesthesia is performed by an experienced anesthesiologist at the current level," etc. If the patient does not trust, and even more so, the surgeon is afraid, one of the medical workers can change his mind, having characterized the doctor on the positive side (the "third person effect"). If this is not possible, it is better to make a decision about changing the operating surgeon.

2.2.5. Deontological approach to relatives of the patient with malignant neoplasms

The relationship of the doctor with relatives and colleagues of the patient is the subject of special discussion. Here play a role as psychological aspects, as well as property, material and a number of other factors. In this case, the interests of the patient come to the fore. No matter how busy the attending physician, he should find time to talk with the patient's relatives. The question is about the life of a loved one, for them this is a serious mental trauma. Perhaps the manifestation of anxiety, excessive care of the patient, less often - inadequate response, some alienation, incontinence. The next of kin should be properly informed about the true diagnosis and the version to be followed in the conversation with the patient, as well as the risk of surgical interventions and prognosis.

In the event that a patient has a first malignant tumor, relatives should help convince him of the need for treatment. The attention of relatives is drawn to the creation of a benevolent, gentle microclimate in the family, including at remote times after radical operations; stresses that stressful situations, experiences, severe mental trauma can contribute to the emergence of new metastases or the emergence of tumors of other localizations. The task of relatives is to suggest to the patient, cured of cancer or suffering from neglected forms of a malignant tumor, the hope of a favorable outcome of the disease, the preservation of his psychological balance.

Relatives often ask questions about the possible duration of the patient's life, especially in the presence of distant metastases. Specific dates should not be indicated. The exact answer in such a situation is difficult to perceive by relatives, and the natural error in one direction or another is lost

by the authority of the doctor. The doctor should be ready to answer and questions about the scope of the operation, the possible infectiousness of the cancer.

Relatives need to be informed objectively, but if possible, leave hope for a favorable outcome. This is especially important in talking with people who are highly motivated or who themselves suffer from diseases of the nervous, cardiovascular and other systems.

With regard to people who underwent radical treatment (III clinical group), it is desirable that relatives, on the one hand, avoid excessive care, but on the other hand they show understanding and patience, and do not allow reproaches in suspicion when a patient has complaints.

An important role in this period is played by the social rehabilitation of the patient, an adequate solution to the issue of his employment. After curing cancer, patients are disabled for some time, which often exerts additional psychotraumatic influence on patients who previously occupied an active life position. A timely return to the feasible labor activity in the family and at work often affects the patient, convincing him of the reality of recovery.

2.3. Ethical and legal aspects of transplantation

2.3.1. Transplantation: past and present.

2.3.2. Moral and legal problems of transplantology.

2.3.1. Transplantation: past and present

The transplantation of human organs and tissue is a replacement of absence-sponding or damaged organs or tissues, which is based on the fence of organs and tissues from a donor or a human corpse, their typification, preservation and storage, and carried out through surgery operation. It should be borne in mind that the human organs and tissue are anatomical structures without defining the distinctive personality traits.

Donor of organs and tissues is a person who voluntarily gives organs or tissues for the transplantation to sick people.

Recipient is a person to whom organs or human tissue are transplanted by therapeutic purposes.

Fundamentals of scientific transplantation were laid in the early 19th century. It is known that in 1804, Baron reported autotransplantation in sheep skin, and the results of successful experiments on skin transplantation from one animal to another, the first of one or another species. 1823 Bünger restored part of the nose of a woman using a free graft transplantation.

If the transplantation was initially developed as part of the plastic surgery, its next phase of development specialists associated with success in surgery, the discovery of anesthesia, the introduction in to clinical practice aseptic and antiseptics, developing vascular suture technique.

1902 – E. Ulman carried out the first attempt at an experimental transplant of kidneys in dogs.

1905 – Carrel reported the first experimental heart transplant in dogs.

1923– in the US (Holman) performed the first transplant of skin from mother to child with burns.

1933 – J. Voronov implemented the world's first transplantation of cadaveric kidneys.

1954 –in the United States (Boston) Joseph Murray performed the world's first kidney transplant from a related homozygous twins, and in 1991 the plastic surgeon became a Nobel laureate.

1965 –the first in the USSR successful kidney transplantation in a clinical setting made Petrovsky.

1966 – London was the legal registration of the concept of brain death, and in 1968 the criteria for brain death were clearly defined in the Harvard Medical School.

1967 – Mr. Bernard (South Africa) has produced the world's first human heart transplant. The recipient was a 54-year-old man with coronary artery disease, and post-infarction left ventricular aneurysm, and donor - a 25-year-ness of women killed as a result of traumatic brain injury.

1970 –the first kidney transplant in the Byelorussian SSR, made in the 4-th city hospital of Minsk academician N. Savchenko.

In the Republic of Belarus, transplantation is one of the highly developed branches of medicine, corresponding to the world best practices.

2008 –the first liver transplantation in Belarus surgeon O. Rummo – 9-th city hospital of Minsk.

2009 –the first heart transplantation in Belarus, made Y. Ostrovskiy.

Today transplantation as a branch of medicine is recognized as one of the most promising in medicine. The level of its operation is not the same in different countries. In general, the service transplantation following requirements: high-quality vocational training; research; adherence to the principles of international cooperation; the formation of a national school of Transplantation.

On March 15, 2010, the Republican Scientific and Practical Center "Organ and tissue transplantation" was opened on the basis of the "9th city clinical hospital in Minsk". Today regional branches in the field of organ donation have been established in all regional centers of Belarus. In 2017, the Republic of Belarus is among the 50 leading countries in the field of organ transplantation.

2.3.2. Moral and legal problems of transplantology

The transplantation is not only a clinical discipline, but also a complex social moral and ethical problem. This branch of medicine cannot develop without the active participation of society in solving its complex

problems, without taking into account the ongoing transformational changes in the world outlook of the society, without constructive social dialogue to solve "open problems" due to the complexity of understanding the diagnosis of "death of a person" and the possibility of saving another patient dichotomy of the complexity and inconsistency of the work of resuscitators and a brigade, stating death).

There are several types of transplantation. They differ from each other not only from the medical, but also from the ethical point of view. Complexity of the situation is that transplantologists should do everything to save the patient's life, but at the same time, the earlier they start taking organs and tissues from the body, the more likely the transplantation will be successful. The conflict is obvious: the struggle for the life of the dying person and the need for the earliest receipt of organs and tissues for transplantation to the recipient. To this day, there is no consensus on how to solve this problem.

In connection with the active development in recent years of transplantation, a growing number of social, ethical and legal problems have become more and more actual: the scientifically established scientific establishment of biological death criteria. In the process of seizure and transplantation of organs and tissues from a deceased donor, the question regarding criteria for the term "deceased donor" for a long time remained unsolved. In accordance with traditional criteria, the irreversible cessation of the work of the heart and lungs is a sufficient basis for ascertaining death, then what is the point of transplanting nonviable organs? In the opposite case, there is no reason to recognize a person as dead. Over time, the organs of deceased donors became possible when a new criterion for the death of a person-the death of the brain-was legalized. It is after this for several days that the work of the heart, lungs, and liver can be artificially maintained;

- the problem of equity in the distribution among potential recipients of scarce organs and tissues of transplantology by immunological indicators, taking into account the order of priority, i.e. on the basis of the waiting list;

- the problem of equitable distribution of scarce health resources;- moral problems of the procedure for organ harvesting from living donors: how and to what extent to guarantee voluntary consent of the donor (consent for coercion, sale of organs and tissues, etc.);

- the donor problem (especially when transplanting such unpaired vital organs as the heart, liver, pancreas, etc.);

- moral problems of organ transplantation from the corpse that gave birth to two legal models of organ harvesting: ***a) presumption of consent ("unsolicited consent")*** - the physician's right to take the necessary organs of the deceased patient for transplantation, since the deceased did not object to it in life, or the relatives do not object (applied in the Republic of Belarus, the Russian Federation, the Netherlands, Sweden, Belgium, Austria, Portugal), ***b)***

the presumption of disagreement ("requested consent") - the legally enforceable right to transfer one's organs to one another to persons for the purpose of their subsequent use after death, or permission to do so by the relatives of the deceased (USA, Germany, Canada, France, Italy);

- ethical problems associated with trafficking in human organs and tissues;
- inadmissibility of using the most vulnerable and vulnerable groups of people as donors: children, patients of psychiatric clinics, homeless people, orphans;
- moral problems of transplantation of fetal organs and tissues;
- ethical aspects of xenotransplantation;
- improvement of legal aspects of transplantation.

What is the moral and ethical status of the deceased person? Is it possible to talk about preserving the human right to your body after death? Is it possible to scientifically grounded donation? Is it morally possible to prolong the life of some people at the expense of others? Does death have an ethical meaning? What are the socio-cultural perspectives of scientific and practical use of man and other complex issues?

In many countries, the level of development of transplantology depends to a large extent on religious beliefs. The problem of donation needs the support of the church, since all leading denominations of the world approve in principle this method of treatment of incurable earlier human diseases.

Activities in the field of transplantation in the Republic of Belarus are based on the Law of the Republic of Belarus "On Transplantation of Human Organs and Tissues" of March 4, 1997 No. 28-3 (as amended on 09.01.2007 No. 207-3) [3].

2.4. Ethical problems of medical genetics and genetic engineering

2.4.1. Biotechnology, biosafety and genetic engineering.
2.4.2. Specificity of moral problems of medical genetics.
2.4.3. The problem of cloning. The moral problem of human cloning.

2.4.1. Biotechnology, biosafety and genetic engineering

The last years of the XX century characterized by the rapid development of biotechnology, based on the achievements of molecular biology and genetics.

Biotechnology is a set of methods and techniques for obtaining time-personal products and energy using living organisms and biological processes. Through the development of methods for the isolation of the hereditary material (DNA), its study (identifying sequences encoding specific genes) creating its new combinations via manipulations performed outside

the cell, and transferring of these new genetic constructions in living organisms have an opportunity to create new plant varieties, the rocks animals, strains of microorganisms having useful features that cannot be selected through traditional breeding.

The history of the use of genetically modified organisms (GMO) in practice small. In this regard, to ensure the safety of genetic engineering and transgenic products is one of the most pressing problems in this area.

Safety of genetic engineering activity or biosecurity, provides a system of measures aimed at preventing or reducing to a safe level of adverse effects of genetically engineered organisms on human health and the environment in the implementation of genetic engineering. Biosecurity knowledge area includes two areas: development, use of risk assessment and methods of prevention of adverse effects of transgenic organisms and the system of state regulation of the safety of genetic engineering activity.

The need to correct "errors of nature", i.e. gene therapy of inherited diseases, highlights this region molecular genetics, which is called a gene (or genetic) engineering.

Genetic engineering – this is the section of molecular biology, applied molecular genetics, which aims to design new targeted, non-existent in the nature of combinations of genes by using genetic and biochemical methods. It is based on the extraction of cells from any organism genes or gene groups, their connection with certain nucleic acid molecules and introducing the hybrid molecules obtained in the other cells of the body.

The problems associated with genetic engineering today, global in scale. Diseases at the genetic level are increasingly conditioned by the development of civilization. Available studies indicate that modern generations about 50% of pathologies caused by disorders in the structure and functions of the hereditary apparatus. Every five out of a hundred infants have a marked genetic defects associated with mutations or chromosomes or genes.

Genetic engineering opens up wide spaces and a lot of ways to solve the problems of medicine, genetics, agriculture, microbiological industry, etc. You can use it purposefully manipulate the genetic material for the creation of new or renovation of old genotypes. Existing developments in this area show the promise of gene therapy in the treatment of hereditary diseases.

However, the question arises about the social and ethical evaluation and the importance of genetic engineering in general, and human gene therapy in particular. Who will guarantee that gene therapy will not be used against a person, as happened to many discoveries in the field of physics, chemistry and other sciences.

There is a problem associated with the fact that gene therapy is based on the introduction into the organism of foreign genetic material, which

means that a direct human intervention genotype. This is what gives rise to some authors oppose genetic engineering.

In Belarus powerful microbiological industry has developed. In particular, the adjusted production of drugs antimicrobial, antiviral, antiinflammatory, antitumor, antileukemic action, amino acids, vitamins, enzymes, hormones, nucleic components, vaccines, blood products, diagnostics and other (more than 300 names). For the needs of agriculture produced a variety of feed supplements, veterinary protection of animal, plant growth regulators and animals, insecticidal, antibacterial, and antiviral biologics wide spectrum of action.

Development of new biotechnologies, great attention is paid to the state-level. In recent years a number of major sovereigns-governmental programs was implemented. This scientific and technical program "Infection and medical biotechnology" and "Industrial Biotechnology" and the state program of fundamental research "Development of scientific basis of biotechnological processes: selection and creation of the collection of non-pathogenic microorganisms as a biotechnological objects; genetic and cellular engineering of plants and microorganisms; microbial synthesis of biologically active compounds and the use of microorganisms in industry, agriculture and the environment ("Biotechnology"). "In addition to conducting research, the program included a series of organizational and personnel activities designed to give an impetus to accelerate the development of this promising scientific field.

The challenge of effective state regulation is to ensure, on the one hand, the most favorable conditions for the development of genetic engineering as one of the priority research areas, and on the other – to guarantee the security in the implementation and use of the results and products of genetic engineering. Another part of this task is achieved through the use of a system of measures to prevent or reduce to a safe level of adverse effects of genetically engineered organisms on human health and the environment in the implementation of genetic engineering. To date, we developed an effective system of safety assessment of genetically engineered transgenic organisms to human health and the environment.

The system of international relations biosafety issues emerged in recent years to the fore. In 2000, the countries – Side-E of the Convention on Biological Diversity (Belarus is a party to the Convention) adopted *the Cartagena Protocol on Biosafety*, the main purpose of which - "Promoting adequate level of protection in the field of the safe transfer, handling and use of living modified organisms resulting from modern bio-technology, can have adverse effects on the conservation and sustainable use of biological diversity, taking also into account risks to human health, and specifically focusing on transboundary movements "(Cartagena protocol, art. 1). The Protocol entered into force on September 11, 2003.

2.4.2. Specificity of moral problems of medical genetics

Genetics is closely linked to moral and ethical sphere because of the deep problems of socialization of biotechnological research, as of today it is one of the most rapidly developing areas of scientific knowledge, which is characterized by rapid practical application.

Traditionally, medical ethics focuses primarily on the relationship between two individuals - the doctor and the patient. One of the main features of the ethical problems of medical genetics is different: it is related to the fact that hereditary diseases (although they occur in individuals) resulting in reproductive processes transmitted descendants.

Another feature of the medical genetics, which manifests itself in the specificity of its moral problems, is that only a very large number of non-hereditary diseases there is a more or less successful treatment. Mostly confined to the measures necessary to preventics and diagnosis of these disorders. The latter circumstance determines the presence of such specific issues as ethics diagnostics of a pathological condition, if not a very efficient method of its treatment.

Specificity of ethical problems of medical genetics is also the fact that the subject of genetic practice is mainly taking care of the health of unborn children – future generations. Therefore, as a type of medical care, medical genetics can only develop in a social situation where both individuals and society as a whole recognize the responsibility for the health of not only living longer citizens, but also those who have yet to be born. The recognition of this responsibility, raises questions over the issue of justice in relation to public resources distribution between generations already living and those who will come to replace them.

In the course of scientific development and application of genetic technologies, serious ethical problems have emerged related to interference in the mechanisms of preserving various forms of life on the Earth, primarily human life. It is a problem of using genetic technologies to improve the human nature; the problem of access of different segments of the population to the possibility of their use; the problem of genetic screening of the population and genetic certification of the population; the problem of securing the secret of genetic information; the commercialization of the use of genetic information and gene technologies; problems of scientific research in the field of development and improvement of gene technologies; problems of transgenic plants and animals.

The idea of genetic improvement of a person assumes that biological signs can be fixed, their quantitative parameters are determined, and they can be programmed. These questions are inseparably linked with the definition of norms and deviations from it, both for the better and for the worse. At present, there are norms not only for the biological processes taking place in

the human body, but also for intellectual, mental, social and cultural development. Deviations from such norms inevitably cause the desire to "fix something" in a person.

Currently, acceptable methods of influencing the mechanisms of human heredity are used after genetic counseling and diagnosis.

Medico-genetic counseling is a type of medical assistance to the population aimed at the prevention of hereditary diseases, which occurs in medical genetic consultations and specialized research medical institutes. It is the exchange of information between a doctor and future parents, as well as people affected by the disease, or their relatives on the possibility of manifestation or recurrence of a hereditary disease in the family. Its main goal is to prevent the birth of a sick child.

Genetic diagnosis is carried out at various stages of the human body in the form of *pre-implantation and prenatal diagnostics*, as well as human *DNA-diagnostics* (from birth to the end of life). In each case, there are ethical problems.

Pre-implantation diagnosis is carried out in the process of using the technology of in vitro fertilization and allows the selection of "genetically healthy" embryos prior to them in the procedure of embryo transfer into the uterine cavity. The method of pre-implantation genetic diagnosis developed at the Institute of Reproductive Genetics in Chicago by a group of scientists led by Dr. J. Verlinsky suggests genetic analysis of the DNA of one of the embryonic cells obtained by in vitro fertilization, which reached the stage of 8 cells and was not yet implanted into the cavity the uterus. In the absence of a pathological gene, the embryo is transferred to the uterine cavity and continues its development. If it is present, the embryo is destroyed and this causes a number of ethical objections due to the uncertainty of the status of the embryo.

Prenatal diagnosis is a genetic diagnosis at the stage of intrauterine development of a person in order to identify the existing genetic pathology or genetic predisposition to the appearance in the future of diseases that significantly alter the quality of human life. It inevitably entails discussion of the question of whether to continue pregnancy.

In this case, the ethical problem is the right to deprivation of life of a potential person who has an inappropriate "level of health". Abortion here becomes a means of getting rid of parents from worries about the life and health of an initially sick child. But this problem has a wider meaning, connected with understanding the attitude of society towards people with disabilities (disabled) and terminally ill.

Expanding the use of methods of prenatal genetic diagnosis for the purpose of taking care of human health leads to a change in the content of the concept of health, which becomes identical with the notion of a "genetic

norm". A consequence of this is the acceptability of the ideas of eugenics about the expediency of "selecting" the most valuable individuals for society.

DNA - the diagnosis of a person at various stages of his life is used to identify the genetic conditionality of the existing disease, as well as in the analysis of organs and tissues intended for transplantation. The use of DNA diagnostics makes it possible to identify the presence of diseases caused by genetic pathology, and a predisposition to a number of somatic and mental diseases. The identification of a predisposition to the development of a disease makes it possible to take appropriate preventive measures. It affects the area of life values and behavioral strategies of only one person, who decides how to use the information he has received about his own health.

When genetic diagnosis of an adult's DNA, the problem of preserving the secrets of medical information and the problem of using the obtained genetic information comes to the fore. Possibilities of modern genetic technologies that allow to obtain information about human anomalies of the genetic apparatus and the associated probability of developing a disease, raise the question of the necessity and desirability for the patient of this information. This question is part of the broader ethical-philosophical question of the desirability for man of the knowledge of his future, especially the unpleasant. Does man want to know that he will inevitably get sick and which disease? Does man want to know the time of his death?

Medico-genetic counseling and diagnosis should be conducted in accordance with the *principles of voluntary informed consent, with the mandatory observance of the confidentiality rule*.

With the advent of prenatal diagnosis, it became possible to screen populations characterized by high frequencies of certain hereditary diseases. Screening allows you to identify couples with a high degree of risk and monitor each of their conception by examining the developing fetus. For example, sickle-cell anemia is detected, often found in people from West Africa. This is of great importance for protecting the health of citizens of the state.

Genetic technologies are aimed, first of all, at rendering a therapeutic effect on the human body in case of genetic diseases, especially those that are severe and disabling it. *Gene therapy* is a new method for treating genetically determined diseases, based on replacing the gene responsible for the disease with a "healthy" gene. The goal of gene therapy is to "correct" the activity of genes that cause or contribute to the development of specific diseases or pathological conditions.

Gene therapy is carried out in two forms*: somatic gene therapy and germ line gene therapy*. *Somatic gene therapy* is such an intervention in the human genetic apparatus, as a result of which the acquired properties are manifested at the cellular level and are not inherited. This type of therapy is allowed in all countries of the world who own this technology. *Embryonic*

gene therapy involves interference in the genetic apparatus of the embryo at various stages of its development. This type of gene therapy is currently at the stage of research and development. According to many researchers, it represents the danger of unknown, unpredictable consequences of modern science not only for the development of man himself, but also for the remote consequences for his offspring.

Many experts note that the boundary between gene therapy and positive eugenics is difficult to determine.

Specialists in bioethics, scientists and representatives of religion pay attention to the danger of spreading the "construction" of children by parents in accordance with desirable signs for them, and it's about choosing not only anatomical and physiological parameters, but also the inclinations of certain abilities, temperament, etc. .

The *problem of the use of genetic information* is becoming more relevant as the use of genetic diagnosis and counseling increases. Who should be provided with information on a person's genetic examination? Is he alone or his relatives entitled to receive it? Does the employer, insurer or other representatives of the society have the right to know information about the characteristics of the human genome? How can a person use this information? Is it lawful to create "genetic information banks" and introduce "genetic certification"? Despite the ethical controversy of many of these issues and their legal uncertainty, much has already taken place in the life of modern society.

The *problem of preserving the secrets of genetic information* is an actual ethical and legal problem due to the fact that in modern society the human right to secrecy of information concerning his personality, the principle of respect for the rights and dignity of the individual, and the genetic information affect all areas of life man - from physical health to the realization of his rights and freedoms in society. DNA samples are more meaningful information about a person than fingerprints or traditional medical data. The DNA available in the database now allows identifying 4000 genetic markers that predispose to certain mental, endocrinological, oncological diseases, propensity to alcoholism, etc.

When creating banks of genetic information about representatives of certain population groups, there is a danger of its misuse, which can lead to different types of discrimination of these population groups.

The laboratory of human genetics of the Institute of Genetics and Cytology successfully operates in the Republic of Belarus. The NAS is the only one in the CIS that has international accreditation in the field of genetic analysis. The center carries out testing for genetic predisposition to cardiovascular diseases, diabetes, osteoporosis, metabolic syndrome (obesity). If this predisposition is identified, then it is possible to prevent and prevent the disease. Also, genetic testing of athletes is conducted to identify

favorable and unfavorable genetic features for sport. The most popular service in the center is the identification of the genetic causes of miscarriage. At least half of the genetic passports are issued to women with this problem. If doctors identify the genetic causes of miscarriages, then doctors can prescribe appropriate therapy for a woman.

Ethical problems in the *creation of transgenic plants and animals* have arisen as a result of extensive use of genetic engineering techniques in the field of improving the quality of plants and animals that are used by man in his life. Transgenic organisms are a product of human activity in the genetic modification of the original natural organisms by transferring the genes of an organism of one species to another.

The creation and use by man of transgenic organisms, especially as food products, causes great concern among specialists because of insufficient knowledge of their influence on human health. The use of transgenic products is, in fact, the introduction into practice of scientific developments, the safety of which is scientifically insufficiently substantiated.

Gene technologies in the religious aspect appear as ways of human activity aimed at transforming what is created by God - man, animals, plants. This raises the question: does man seek to play the role of God or fulfill the destiny of God?

Man, created in the image and likeness of God, has the ability to create. Genetic technologies can be regarded as the fulfillment by man of his destiny in the world - the perfection of all existing in the world, including man. Therefore, to make a person with the help of genetic technologies is smarter, healthier, stronger - it is to act in accordance with the intentions of God.

Opposite to this is the view that a person, intruding into the foundations of life, thereby trying to gain power over life, while being guided by a certain model of the ideal person, the desired qualities of animals, plants, etc., which is formed in society in certain culturally -historical conditions.

The Russian Orthodox Church believes that "the development of medical genetic methods of diagnosis and treatment can help prevent hereditary diseases and alleviate the suffering of many people. "However, the goal of genetic intervention should not be the artificial" improvement "of the human race and the invasion of God's plan for man. Therefore, gene therapy can be carried out only with the consent of the patient or his legal representatives and exclusively for medical reasons. Gene therapy of germ cells is extremely dangerous, because it is associated with a change in the genome in a number of generations, which can lead to unpredictable consequences in the form of new mutations and destabilization of the balance between the human community and the environment "[4]. The Russian Orthodox Church noted that the methods of prenatal diagnosis are of a dual nature. "Some of these methods can pose a threat to the life and integrity of

the test embryo or fetus. ... Prenatal diagnosis can be considered morally justifiable if it is aimed at treating the identified ailments at the earliest possible stages, as well as preparing parents for special care for a sick child. Everyone has the right to life, love and care, regardless of the presence of certain diseases. ... It is absolutely unacceptable to apply methods of prenatal diagnosis in order to choose the sex of the future child that is desirable for the parents. "

The ***legal aspect*** *of the development and application of genetic technologies* is reflected in a number of international ethical and legal documents and domestic legislation. This is the *Declaration of the Human Genome Project (1992), the Declaration on Genetic Counseling and Genetic Engineering (1987) of the World Medical Association, the Council of Europe Convention on Human Rights and Biomedicine (1997), the Law of the Russian Federation on State Regulation in the Field of Genetic Engineering Activities "(2000), Law of the Republic of Belarus "On the Safety of Genetic Engineering Activities of January 9, 2006 No. 96-3.*

In the Declaration on the Human Genome Project, *respect for the person's personality, his autonomy and the principle of non-interference in his private life, as well as a comparative assessment of risk and benefit, are put forward as the main criteria for the evaluation of the project*. The Declaration notes the danger of using genetic information for non-medical and eugenic purposes.

In the "Convention for the Protection of Human Rights and Human Dignity in Connection with the Application of Biology and Medicine: the Convention on Human Rights and Biomedicine," chapter IV is devoted to ethical norms and principles governing activities in relation to the human genome. Article 11 prohibits any form of discrimination against a person on the basis of his genetic heritage. Article 12 states that prognostic tests for the presence of a genetic disease or a genetic predisposition to a particular disease can be conducted only for medical purposes or for the purposes of medical science and subject to proper consultation by a geneticist.

"Intervention in the human genome, aimed at modifying it, can be carried out only for preventive, diagnostic or therapeutic purposes and only provided that it is not aimed at changing the genome of human heirs" (Article 13). Thus, interference in the genome of an individual, affecting only his life, but not affecting the representatives of his genus, is recognized. In the Convention (Article 14), there is also a prohibition on the use of gene technologies for the purpose of sex selection, except when it is due to a hereditary disease associated with sex.

Thus, at the level of legal norms, the requirements for carrying out genetic research and the use of gene technologies are consistent with the main ethical principles and norms of modern biomedicine.

2.4.3. The problem of cloning. The moral problem of human cloning

The term "cloning" means the exact reproduction of an object an indefinite number of times. The objects obtained as a result of this action are called "clones". By cloning a person is understood as an opportunity to create a clone of a person who will reproduce the donor person not only externally, but also at the genetic level. However, some individually identified signs in a donor person and a clone will differ, for example, capillary patterns of fingers. In this case, the donor can be not only the now existing person, but also our ancestor (in case it can have DNA).

Cloning can be divided into two types. Firstly, it is therapeutic cloning, as a result of which the development of the embryo appears after 14 days, and he himself is used to obtain stem cells. The term of 14 days is due to the fact that later the human personality begins to manifest itself, expressed in particular in the appearance of the rudiments of the nervous system. Secondly, this is reproductive cloning, as a result of which a human clone appears. It is this type of cloning that is banned in most states, including Russia, the Republic of Belarus, the United States.

To the *moral and ethical issues of human cloning* are the following problems: Is it moral that a person appears artificially, and not naturally; whether people have the right to create their own kind (putting themselves in the place of nature), etc. The legal issues include the following: to prohibit or not to prohibit this procedure, impose an interim prohibition, legislative regulation of the legal status of clones, regulation of cloning procedures.

Today, an obstacle to human cloning can be considered:

1. *Technological difficulties*, due to the fact that the cloning technology is not developed now, as a result, a large number of unsuccessful attempts occur. In addition, there is one significant restriction for cloning, namely, not the possibility of a repetition of consciousness;

2. *Socio-ethical aspect*, i.e. due to the fact that the technology as mentioned above is not worked out, there is a high probability of occurrence of a large number of defective clones - the emergence of persons with genetic mutations, etc. And this, in turn, is a threat to the entire human species;

3. *Ethical and religious* aspect. Most religions for human cloning are negative, for example the ROC does not oppose research in this area, but opposes the cloning of humans. This is due to the fact that a person is "the creation of God," a person can not put himself in the place of God and create clones for himself, because it is pride, and it is known to be punishable. The legend of the Tower of Babel, described in the Bible serves as a vivid example of this, the punishment at that time was the confusion of languages;4. From the point of biological safety of the species, this question is also quite controversial. We have already talked about possible mutations that can occur due to the "dampness" of the cloning technology itself.

The issue of cloning was actively discussed at the level of governments of many countries. The Council of Europe, in addition to the Convention on Human Rights and Biomedicine, adopted a protocol on the prohibition of human cloning. The same is called for by Article 11 of the UN Universal Declaration on the Genome and Human Rights: "A practice contrary to human dignity, such as the practice of cloning a human being, is not allowed. States and competent organizations are invited to cooperate in order to identify such practices and take the necessary measures at the national and international levels in accordance with the principles set forth in this Declaration. "The Intergovernmental Bioethics Committee of UNESCO (Paris, 2001) urged Member States of the Organization "to take appropriate measures, including legislative and regulatory measures, to effectively prohibit human reproductive cloning".

2.5. Ethical and legal regulation medical-biological experiments on animals and people

2.5.1. Ethical and legal aspects of the regulation of biomedical research involving human subjects: international instruments.

2.5.2. Ethical Aspects of Using Animals in Biomedical Research.

2.5.3. The role of bioethical committees in solving social and professional health problem.

2.5.1. Ethical and legal aspects of the regulation of biomedical research involving human subjects: international instruments

Modern medicine and pharmacy increasingly lose their resemblance to craft and art and become experimental research activities. The need to obtain objective reliable knowledge requires an experimental justification.

The beginning of the existence of medicine and pharmacy in the status of experimental science had a tragic coloring: the experiments of fascist doctors over prisoners of concentration camps in the 40s of the XX century. During the Nuremberg trials of Nazi scientists and doctors, many facts were confirmed, documented and testified about these experiments, which raised the issue of the protection of the rights of test subjects, the need to restrict research on a person within certain limits. During the Nuremberg process, a document was developed, known as the "Nuremberg Code" and was essentially the first international document that included the ethical and legal principles of research in humans. The key principles in this code were "the need for the voluntary consent of the object of the experiment" to participate in the study, its ability to act and information about the nature of the experiment.

Research in humans is divided into two types: medical and biological research (non-clinical, non-therapeutic) and clinical (therapeutic) studies.

Medico-biological studies study the reaction, the change in the state of the organism of healthy people under the influence of certain external factors. Such research is carried out in the interests of science, supplement and improve scientific data, but have no direct relation to the treatment of diseases. Clinical studies are carried out in the interests of the patient in the treatment of diseases.

At the present stage, biomedical research involving human beings, protection of human rights and dignity is regulated by a number of international documents that are the basis for the development of national strategies and programs for the development of bioethical organizations. In this connection, the following questions are topical: how can human rights and duties be ensured in biomedical research? What values should be taken into account in health research? What sociocultural boundaries should be set before science and health service to focus on humanistic values in conducting biomedical research? What consequences can society expect in conducting biomedical research?

The main problems of research in the field of health service are: the use of control agents (placebo); informed consent; adherence to standards of medical services; discussion and consultation with the public; access to research; functions and responsibilities of ethics committees; compensation for damage during testing; preservation of medical confidentiality and confidentiality of information received; treatment in the course of research; availability of the product; sponsorship; liabilities and insurance; use of human tissues; research of stem cells; exercise of ownership of the data; informing about the right of ownership, etc.

Documents regulating biomedical research are developed by a number of international organizations, including WHO, the World Medical Association, UNESCO, the Council of Europe.

Documents vary in terms of scope, as well as in their legal force. For example, the Nuremberg Code is only a kind of moral imperative, and such as the Council of Europe Convention on Biomedicine and Human Rights, the Convention on Bioethics (1997) and its Additional Protocol on Biomedical Research (2005) - are legal instruments that must be respected those countries that have acceded to them and ratified them.

Among the documents adopted in recent years, we can name:

• The Helsinki Declaration of the World Medical Association "Ethical Principles of Medical Research with the Participation of a Person as a Subject" (as amended in 2000, with explanations of 2002);

• Additional Protocol to the Council of Europe Convention on Biomedicine and Human Rights concerning biomedical research (2005);

• The UNESCO Universal Declaration on Bioethics and Human Rights (2005), which raises the issue of biomedical research in many articles;

• Council of Europe recommendations on research conducted on biological materials of human origin (2006).

• In Belarus, biomedical research on a person is conducted on the basis of the Laws of the Republic of Belarus "On Health Service" (No. 2435-XII of June 18, 1993: as amended and supplemented by the Law of the Republic of Belarus No. 363-3 of June 20, 2008) On the safety of genetic engineering activities "(2006)," On medicines "(2006)," On transplantation of human organs and tissues "(2007); a number of Resolutions of the Council of Ministers of the Republic of Belarus, and in accordance with the order of the Ministry of Health of the Republic of Belarus "On Approval of the Rules for Conducting Clinical Trials of Medicines" (1999), on the basis of which the Republican Center for Expertise and Testing in Health Service was established, and the Order of the Ministry of Health of 17.04.2006 № 274 "On the establishment of the National Committee on Bioethics".

A special role among international instruments regulating biomedical research involving human beings belongs to the Helsinki Declaration. Despite the fact that it is not a legally binding document, however, its significance is undeniable. The main provisions of the Helsinki Declaration are the legal norms of a number of national legislations.

The basic ethical requirements of the Helsinki Declaration:

• Lack of personal dependence of the test subject. There is a specific group of people who are considered "vulnerable". "Vulnerable" is usually called, first of all, children, subjects with mental disorders, pregnant women, military, medical students, prisoners. These groups are "vulnerable" because they are not completely free from compulsion of the experimenter, boss or their position for various reasons. Risk of harm and abuse is possible.

• Those who are incompetent can participate in experiments with the consent of guardians, but only in therapeutic trials.

• All studies should be scientifically based and based on animal experiments. A guarantee is required for the accuracy of the results and their publication.

• The ethical purity of the experiments is guaranteed by their ethical expertise: the goals and methods should be set out in a special protocol and approved by the ethical committee.

• Refusal to conduct research should not affect the deterioration of the relationship between the doctor and the patient.

An important point in conducting biomedical research is the observance of the principle of informed consent. Participants in the experiment should be provided with complete and accurate information in an understandable and accessible form. This information:

- about the research objectives;

- about possible benefits and risks associated with participation in the study;- about alternative methods of diagnosis or treatment;

- of his right to terminate his participation at any time;

- and that refusal to participate will not affect the medical care received by this person.

2.5.2. Ethical aspects of the use animals in biomedical research

The use of animals in medical research is one of the most important and fundamental problems of bioethics. The accumulated experience testifies to the necessity of carrying out experiments on animals before the first test of new drugs in humans. The Helsinki Declaration states that biomedical research in human beings must conform to generally accepted scientific norms and principles and be based on previously performed experiments and experiments on animals in the laboratory, as well as extensive knowledge of the scientific literature. This code of ethical principles justifies the need for careful treatment of animals, which are used by scientists in the conduct of scientific research.

The preclinical stage of research is due to the following factors:

- preliminary study on animals in accordance with the developed requirements are the basis of their safe use in practical medicine;

- the use of animals in scientific experiments is necessary for the development of biomedical sciences, which makes it possible to better understand the laws and mechanisms of the course of life processes;

- study of the negative effect of the study drug on the organism of experimental animals makes it possible to determine which tissues and organs are more sensitive to this preparation and what should be emphasized in conducting clinical trials. Experiments on animals make it possible to study how the studied substance affects the organs with the use of histological methods, the effect of various substances on fetal fetal development, possible mutagenic or carcinogenic effects and other adverse side effects. The famous scientist I.P. Pavlov wrote that "the more fully the experience is made on animals, the less often the patients will have to be in the position of an experimental object with all the sad consequences."

Observance of ethical principles in the conduct of animal experiments has become an indispensable condition in all countries of the world. This becomes one of the criteria for assessing the country's civilization. The Council of International Medical Scientific Organizations (SMMNO) in 1985 issued the "Code of Ethics", containing "international recommendations for carrying out biomedical research using animals." In this ethical code, the theoretical principles and ethical rules optimal for animal scientists have been developed and formulated, which can and have become the basis for the development of regulatory measures and regulatory documents in various states on the use of animals in biomedical research. The main postulates were the following:

- the use of animals in scientific research is undesirable;

- priority should be given to methods that do not require the use of animals;

- at this stage in the development of science, the use of animals is inevitable;

- moral imperative of scientists - humane attitude to experimental animals, avoid causing pain to them and strive to find the opportunity to receive the same results without using animals;- providing the best possible conditions for animals used in biomedical research.

Russell and Birch developed the concept of the "three R", which for the last decades are guided: to solve ethical problems when using animals in experimental biology and medicine Reduction - reduction in the number of animals; Replacement - replacement of animals with highly organized psyche on those below on the evolutionary ladder; Refinement - sparing relief from suffering.

The EU Directive 86/609 / EEC and the EU agreement on the protection of vertebrates and other purposes (1986) decides that an experiment is prohibited if there is another scientifically acceptable method for obtaining the desired result without using animals.

Alternative methods at the moment are:

- storage, use, exchange of information obtained in previous experiments with animals, so as not to repeat them again;

- use of chemical, physical methods, prediction based on chemical and physical properties of molecules;

- operation of game mathematical and computer models, creation of models of biochemical, physiological, pharmacological, toxicological and behavioral systems and processes;- the use of in vitro methods, including the cultivation of human tissues;- use in experiments of organisms with lower organization, weak sensitivity;

- carrying out experiments using vertebrates, but at earlier stages of their development, which precede those stages where their use is regulated by law;

- conducting experiments involving people, including volunteer participants, to study side effects;

- epidemiological observations.

The dissemination and application of alternative methods by scientists makes it possible to reduce the number of animals used to obtain new knowledge; reduce to the minimum values the frequency and intensity of inhumane procedures applied to animals used in experiments; replacing animals with alternative biological models. The low efficiency of animal use in testing and testing of medicines is demonstrated by the fact that about 90% of new drugs are being rejected in the early stages of clinical trials, despite the fact that they have been studied for a long time in animals by specially

designed schemes where they were tested for acute and chronic toxicity, and were tested for carcinogenic, mutagenic and other side effects.

At the same time, one should be objective and remember those positive results that animal experiments lead to, enabling medicine and pharmacies to develop more quickly and efficiently. And this imposes on the shoulders of scientists responsibility for the justification of the need for preclinical testing, adherence to legislative and ethical standards in conducting experiments using animals, i.e. from the value representations of the scientist, his moral image depends reliability and objectivity of the received knowledge, which prove the effectiveness, effectiveness, expediency of using animals in the experiment.

2.5.3. The role of bioethical committees in solving social and professional health problem

Modern medicine is largely a medicine for research, experiments and clinical trials conducted on animals and humans. At present, the world trend in the development of modern health service, biomedical technology and scientific research is inherently linked to the control over observance of ethical norms and human rights.

Today there are standards of practice that have been developed and tested by practice, as well as structures and mechanisms that allow monitoring compliance with these standards. The main principle in conducting clinical trials is the protection of the rights and health of subjects. A peculiar mechanism for implementing this principle is the ethical control of any clinical research, which involves not only testing new drugs, but also testing new medical equipment and medical supplies, surgical intervention, epidemiological research, research in genetics, psychology, etc.

Today this control is carried out in the entire civilized world through institutionalized social technologies, equipped with a system of standardized liberal values that ensure the observance of personal rights and freedoms in the field of biology and medicine. These mechanisms of control over the activities of doctors and scientists are activated by the formation of new institutions in the world health system - ethical (bioethical) committees. Their main functions are advising, making decisions and evaluating ethical, legal and social issues related to the protection of human rights and dignity in the field of clinical medicine and in carrying out an independent ethical review of biomedical and other types of research involving human and animals, as well as bioethical education and education of specialists and the public. Such committees, which carry out advisory, advisory and control functions, function successfully in all civilized countries of the world, which enables operative international cooperation in coordinating actions on the protection of human rights in the field of bioethics.

Bioethics committees are modern conditions the most important structure for compliance with the normative acts adopted by UNESCO as one of the leading international organizations in the field of bioethics.

In the Republic of Belarus, in accordance with the Social and Human Sciences Program of the UNESCO Moscow Office and on behalf of the Council of Ministers of the Republic of Belarus of July 26, 2005, No. 05 / 137-143, in order to ensure public control over compliance with ethical norms and rules in the performance of works related to the use human and animal as objects of experimental and clinical research, observance of human rights and freedoms when using modern achievements of science, educational, medical and other activities in relation to it, the National by Bioethics Committee. The Regulations on the activities of the Committee have been developed, and its members have been defined.

The National Committee on Bioethics is called upon to promote and promote worldwide confidence-building, consolidation and patients, and seek consensus through objective and principled discussion of morally complex situations. The National Committee on Bioethics considers everything related to the observance of the general principles of humanism, morality and biomedical ethics. The methodological foundations of the activities of the national committees are the theoretical guidelines of biomedical ethics and international documents on public control over the observance of human rights in accordance with the Helsinki Declaration and the International Charter of Human Rights.

Thus, mechanisms are being created to protect the rights of citizens against the negative consequences of applying modern bioethics technologies, which envisage the development of ethical codes, laws, increasing the responsibilities of medical professionals and biologists, and expanding their social responsibilities, fixed not only at personal but also legal levels. Such mechanisms of control over the activities of doctors and scientists are activated by the formation of new institutions in the system of world healthcare-committees of its bioethics.

Ethical committees exist for research organizations, hospitals, professional associations (medical, nursing, pharmaceutical), state bodies (parliaments, presidential administrations), international organizations (UNESCO, WHO, Council of Europe, etc.).

Today the following *types of bioethical committees* operate in the Republic of Belarus:

• National Committee.

• Associations of professional doctors (dentists, cardiologists, psychiatrists, etc.).

• Local ethics committees in medical institutions, hospitals, medical universities.

• Bioethics Research Committees and Centers (National Coordinating Center for Safety at the Center for Expertise and Testing in Public Health, Pharmacological Committee).

Thus, complex bioethical problems affect many aspects of the development of modern communities. Therefore, to solve them, a special kind of social institution of ethical committees has been created, which is a multi-level network of public, state and, more rarely, private organizations.

References:

1. Ares, F. A person facing death / F. Ares. – Moscow: Progress-Academy, 1992. – 490 p.
2. Additional Protocol to the Council of Europe Convention on Biomedicine and Human Rights concerning biomedical research [Electronic resource]. - Access mode: http://docs.cntd.ru/document/901921573.
3. The Law of the Republic of Belarus "On Transplantation of Human Organs and Tissues" of March 4, 1997 No. 28-3 (as amended on 09.01.2007 No. 207-3).
4. 16 Bishops' Council of the Russian Orthodox Church. Moscow, August 13-16, 2000. Fundamentals of the Social Concept of the Russian Orthodox Church. XII. Problems of bioethics. http: // www.russian-ortodox-church.org.ru/sdl2r.htm
5. Biomedical ethics: textbook allowance / ed. T. Mishatkina, S. Denisov, Ya. Yaskevich. Minsk, 2009. – 351 p.
6. Kopiyak, A. The problem of human cloning: moral and ethical and legal aspects / A. Kopiyak // Modern scientific research and innovations. – 2012. – №2 [Electronic resource]. URL: http://web.snauka.ru/issues/2012/02/8992 (reference date: 02.06.2017).
7. Global bioethics in the social dimension: materials of scientific-practical conference, Minsk, 16-18 December 2015 / comp., Responsible. Ed.: T. Mishatkina, S. Melnov, L. Loginovskaya. - Minsk: UNESCO-IPEI them. AD Sakharova BSU, 2016. - 278 p.
8. Shastny, A. Biomedical ethics and communication in health service. Problems of Biomedical Ethics / A. Shchastny, M. Korolev, A. Myasoedov, I. Martinkevich, N. Tikhanovich. – Vitebsk: VSMU, 2017. – 76 p.

3. MODERN MEDICAL DEONTOLOGY

3.1. The essence and problems of medical deontology.

3.2. Basic models of relationships in the "doctor-patient" system.

3.3. Paternalistic and autonomous model of relationships. The model of "weakened paternalism." The principle of "informed consent" and "cooperation" between the doctor and the patient.

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3.1. The essence and problems of medical deontology

The introduction of new technologies into medical practice, the actualization of such problems as transplantology, euthanasia, etc., the need for moral and ethical and legal regulation of emerging conflicts became the basis for the establishment of biomedical ethics in the second half of the 20th century. One of its components is medical deontology. The term "deontology" was proposed by the English sociologist and jurist Jeremiah Bentham (J. Bentham) in the 19th century to designate the theory of morality. However, the foundations of deontology were laid in the medicine of the ancient world.

Deontology (from the greek «deon» - duty, due, «logos» - science, teaching) - the doctrine of the due. "To observe duty" means, therefore, to fulfill certain requirements. Medical deontology is a doctrine about the principles of due in medical practice.

Medical deontology in the broad sense is the teaching about the behavior, relationships and actions of the doctor, which are necessary for shaking the psyche of the patient, his loved ones and others, the correct organization of the treatment process, the full use of all possibilities in the provision of care to the patient.

Deontology in a narrower sense - the doctrine of duty, responsibility, honor and dignity of medical staff; principles, norms and forms of relationships in the field of health, directly or indirectly affecting the effectiveness of the treatment, rehabilitation or prevention of a particular patient's disease.

Today deontology is also understood as the doctrine of duty, the science of the moral, aesthetic and intellectual appearance of a person dedicated to the noble cause of caring for human health, about the relationship between physicians, patients and their relatives, and between colleagues in the medical collective and whole institutions involved in the

struggle for human life and health. The methodological basis of deontology is modern philosophy, which has absorbed all the achievements of world culture, and ethics with its universal moral values.

Deontology is not ethics, but it is not a branch of medicine, but a boundary discipline between ethics and medicine that has its own specifics.

However, deontology is meaningfully significantly narrower than ethics itself. Deontology includes certain rules, regulations, prohibitions, which must be followed by a medical professional or a doctor. Medical ethics, unlike deontology, not only answers the question "How", but also "Why?". The difference between deontology and ethics lies mainly in the fact that ethics, regulating through the moral norms, principles, ideals of the relationship between people in society, seeks to preserve and multiply the human race, medical deontology is aimed at preserving the life and health of each particular patient. It is this that determines the subject, norms, principles and tasks of deontology.

The main task of medical deontology, along with medical ethics, is the optimization of the health process, which is achieved not only by improving the means and methods of medical practice, but also by unconditional fulfillment by doctors of their duty on the basis of high professionalism. In doctors of all specialties, their general medical training, possession of modern methods of prevention, diagnosis, treatment and rehabilitation, psychotherapeutic art, strict observance of internal rules (attitude towards work, discipline, friendliness and a sense of collegiality) and external (decency, good tone and appropriate appearance, that is, outward neatness) of the culture of behavior, the presence of high moral qualities, such as humanity and loyalty to duty. The duty of the doctor is to fulfill all the requirements associated with his work. All his actions and thoughts, his relationships with colleagues and other participants in the health process, he must subordinate to the only goal – to succeed in medical activities, to cure the patient, while preserving the honor and dignity, as their loss will make it difficult and even impossible for a doctor to fulfill his professional duty.

However, the problem of the doctor's relationship with direct and indirect participants in the medical process is difficult to resolve on the basis of only common deontological principles, without the doctor's ability and desire to penetrate into the psychology of the persons acting in this process, to understand the patient and his relatives, to create the necessary and useful psychological climate for the successful course treatment, rehabilitation or disease prevention. And this means that mastering the general knowledge of norms and principles of deontology is ineffective in the work of a doctor without a deep assimilation of practical and social psychology. To a certain extent, it can be said that medical deontology is based on this assimilation, and since in his work the doctor routinely deals with specific and different

people in his reactions, each of them needs an individual approach, taking into account their psychological characteristics, socially and individually conditioned behavioral and ideological stereotypes.

Medical deontology is the same for all medical workers. At the same time, the peculiarities of the professional activity of doctors of various specialties assume different approaches in the implementation of deontological provisions. Medical specialties vary considerably, therefore, the deontological requirements regulating the practical activities of medical specialists are specific. There are deontology of the therapist, surgeon, obstetrician-gynecologist, pediatrician, oncologist, psychiatrist, dermatovenerologist, etc. The task of deontology also includes the legal education of a doctor, since the doctor must coordinate his actions with the patient and his relatives with the legal norms. They also determine the level of legal responsibility of a doctor to society.

Deontology extends its demands practically to all aspects of medical, rehabilitation and preventive processes. *The main areas of action of deontology*:

• the relationship between the doctor and the patient, including in the presence of other patients and in the presence of colleagues;

• the relationship between the doctor and child patients;

• the relationship between the doctor and the patient's relatives, including in the presence of the latter and in the presence of outsiders;

• the relationship between the doctor and his colleagues, in that; number in the presence of the patient, his relatives and strangers;

the relationship between doctors and middle (junior), medical staff, including in the presence of patients:

• the attitude of the doctor to medical confidentiality and his right to disseminate information;

• the right of priority in medical activity and the right of the doctor to experiment;• the doctor and his material and moral reward;

• doctor and legal responsibility;

• doctor and policy.

It should be noted that in the health service of any country, with any level of development of culture, regardless of social order and political form of government, deontology solves the same tasks and, consequently, its principles and norms are unified throughout the world. As a rule, they are reflected in the deontological codes adopted by the medical community of a particular country.

In the Republic of Belarus, a deontological code has been developed that can and should be used by doctors in their daily practice. It reflects the fundamentally important, necessary and universally valid for each doctor moral, ethical, psychological and legal norms and principles of the relationship between the physician and participants in the treatment process

(patient, relatives, colleagues, etc.). The code can serve as the basis for additions related to the specifics of each medical specialty. Knowledge of the basic provisions of the code and constant treatment will help to form strong stable deontological stereotypes in the minds of future doctors to ensure the deontological morality of the doctor.

Thus, in the professional mindset of medical professionals of any specialty, the concept of duty or due is extremely important, and the main principle of deontology is the conscious subordination of personal interests to the interests of society.

Today, deontology is understood as the doctrine of duty, the science of the moral, aesthetic and intellectual appearance of a person who has dedicated himself to the noble cause of caring for human health, about the relationship between physicians, patients and their relatives, and between colleagues in a medical team and whole institutions involved in the struggle for human life and health.

3.2. Basic models of relationships in the "doctor-patient" system

An important role in the professional culture of the physician is played by the structure of social relations in the "doctor-patient" system, since it determines both the content and the ways of reproduction or replacement of actual patterns, thereby determining the character of the formation and form of the dynamics of the professional culture of the doctor. Sociocultural processes of the second half of XX century caused the tendency of the transition from a paternalistic to an autonomous model of relationships in the "doctor-patient" system.

We believe that the traditional medical ethics and deontology based on the teachings of Hippocrates, in conditions of intensive use of the latest biomedical technologies, largely cease to correspond to the needs of the new system of medical and patient relations, the specialist and society, the medical community and the health system and do not meet the spiritual, intellectual, cultural, political and economic characteristics and needs of modern society. Therefore, today there is an urgent need to transform the old deontological ideas and create a new medical ethic, to which the majority of bioethics scientists (R. Witch, A. Ivanyushkin, T. Mishatkina, T. Pokulenko, P. Tishchenko, J. Childress, B. Yudin and others).

Modern medical practice is a complex differentiated system in which doctors and patients can be in very different forms of professional interaction. Each of these forms reflects, firstly, certain healing traditions existing in a given society, and, secondly, the specificity of the condition which the patient has. The most recognized models the typology of R. Vich [2], which distinguishes four models of the relationship between the doctor and the patient:

1. A *model of a technical type,* within which a doctor behaves as an applied scientist, avoiding value judgments, moral issues.

2. A *model of the sacral type* - turns a doctor into a priest, caring more for the soul than for the body; the basic moral principle of this type is "by helping the patient, do not harm him."

3. A model of *collegial type* - suggests that the doctor and the patient should see each other in their colleagues, striving for the common goal of eliminating the disease and protecting the patient's health; Trust plays a crucial role in this model.

4. The *contractual model* is based on a contract or agreement (in the notion of a contract, one should not make any legal sense); this model allows to avoid rejection of both the moral norms on the part of the doctor (which is typical for the technical model) and moral expectations on the part of the patient (which is typical for the model of the sacred type), as well as the false and uncontrolled equality of the collegial type model. In a relationship based on a contract or "informed consent" of the patient, the physician is aware that in cases of meaningful choice, it is for the patient that freedom must be maintained to control his life and destiny.

These models of the doctor-patient relationship are ideal constructions: in specific situations, none of them, as a rule, is realized in a pure form, although the interaction of the doctor and the patient can be constructed in accordance with one of the models. The real choice of the type of relationship is determined by the characteristics of the physician's personality, the specific situation of the patient's condition, the nature of the medical care, and so on.

Therefore, four models of relationships are distinguished, the nature of which is determined by the *patient's condition* (i.e, taking into account the biographical plan of the disease):

- *relations with the patient in the acute period of the disease,* when patients can be passive participants in the doctor-patient relationship; The main task of the doctor here is to cure the patient and to return him as soon as possible to the old way of life;

- *relationships with chronic patients* whose lifestyle requires the doctor to be competent and create self-help groups; the main task is to realize the principle of equality and mutual understanding in the process of treatment;

- *relationships with people with disabilities* who may be competent and incompetent in relation to their illness; the doctor's task is to help the patient adapt to the conditions of disability, but not to leave him confined to his bunk or room;

- a*relationship with a dying person,* when the doctor's task is to provide anesthesia, care, moral support and dignified dying. The considered models of relationships in the "doctor-patient" system are not the only ones.

Other models are also proposed. For example, T. Parsons singles out a model of consensus or consensus, a negotiation model, a model of cooperation; K. Berry offers models that characterize the behavior of a modern doctor: Parent, Fighter with disease, Good engineer-technologist, Contractor, Teacher, Mutual loyalty agreement.

Others argue that throughout the history of the development of medicine to this day, there were four forms and models of the relationship between the doctor and the patient: *the Hippocratic model (do no harm), the Paracelsus model (do good), the deontological model ("compliance of duty") and a model of bioethics (biomedical ethics*), which in turn is represented by two forms - liberal and conservative. The four listed historical models of relationships are logically related, and together they form a holistic phenomenon - the professional ethics of the medical community.

Thus, medical practice and medical ethics went through a complicated search path in search of the most optimal type of interaction between the doctor and the patient in the fight against the disease, having worked out various models of relationships in the "doctor-patient" system, but among them, in our opinion, two main ones - paternalistic and autonomous. The question of the relationship between these two types of relationships in the "doctor-patient" system in modern medicine is very relevant, because depending on how these relationships are understood, it depends whether the professional culture of the doctor will undergo serious typological changes in the near future or not.

3.3. Paternalistic and autonomous model of relationships. The model of "weakened paternalism." The essence of the autonomous model of relationships in the "doctor-patient" system. Priority of the autonomous model of relationships and the principle of "informed consent". The principle of "informed consent" and "cooperation" between the doctor and the patient

Today, in Belarus and Commonwealth of Independent States (CIS), most doctors adhere to the traditional paternalistic models of relationships with patients.

Paternalism is based on the inequality of the parties involved in the treatment and diagnosis process and the full subordination of the patient's actions to the prescriptions of the doctor. This type of relationship does not take into account the specific characteristics of the subject (object), its activity, free will. Therefore, it was required to develop a more adequate model based on fundamental democratic values, which are, in particular, solidarity, complicity, compassion, the idea of communist interests. That is why, on the recommendation of the WHO, a new, autonomous model of the doctor-patient relationship is developed and widely implemented, proceeding

from the patient's autonomy principle and assuming a completely different type of relationship. In case the patient's autonomy is recognized, the doctor should rely on the patient's own ideas about what is good for him, or rather - to solve this issue in a dialogue with him, not considering his own views as the only correct ones. In another way, the question of informing the patient is also solved. If, in the paternalistic model, it is dependent on the goodwill or desire of the physician, in this case it acts as its duty, and accordingly information becomes the patient's right to know about all the existing ways of treating his illness and the risk associated with each of them. It is clear that the choice and responsibility are shared between the doctor and the patient. Legally, the patient's autonomy model with the principle of informed consent is enshrined in the Law of the Republic of Belarus "On Health Service" (2001).

In the domestic and Western science, the system of values in the solution of theoretical and practical problems of modern medicine and healthcare, proposed by TL Bosham and JF Childress [1], which includes four interrelated principles: autonomy, do no harm, good deeds, justice, and a system of complementary rules: truthfulness, privacy, confidentiality, fidelity, informed consent. With the help of these principles and rules, the equality and independence of the doctor and patient as partners, the active role of the patient and his right to self-determination during treatment or examination are realized.

What exactly is the protection of the patient's rights in an autonomous model? Firstly, in providing the patient with complete and comprehensive information about his health status, diagnosis, treatment methods, risk, possible therapy options and its outcomes. Secondly, in asserting the right to self-determination of a patient, to choose a medical intervention, according to his understanding. Thirdly, the doctor is obliged to realize the choice of the patient with consistent information about the progress and results of diagnostic procedures and treatment. Moreover, the peculiarity of informed consent is not only the admitted contradiction between objective medical indications and the wishes of the patient, but also the adoption of a subjective decision sometimes on deliberately biased grounds. In this regard, the role of the physician in the "informed consent" system of relationships is to solve three tasks: preparation and submission of information that should help the patient make the right decision and at the same time be free from coercion and manipulation; recognition of the patient's autonomous decision; conscientious implementation of the treatment chosen by the patient.

The principle of "*informed consent*" carries certain protective functions for the patient: it is aimed at overcoming the patient's imposing the will and the views of the doctor on the method of treatment and protecting the patient from the experimental and testing intentions of the specialist; The information model, reflecting the current specialization of medical

knowledge, presupposes the provision of information of high professional quality; Informed consent implements the patient's autonomy principle, emphasizing not only a certain legal status of the patient within whose boundaries treatment is to be performed, but also the patient's right to a decision that corresponds to his own values and perceptions of life and death.

In addition, this model provides for equal partnership in the dialogue "doctor-patient", which increases the responsibility of the patient in making decisions about treatment, prevention, medical rehabilitation. Thus, the principle of informed consent can be considered as a long-sought and finally found form of legal protection of the risks of a doctor uninsured from medical errors.

At the same time, realizing the right of every citizen to inform about his state of health, the doctor should not lose sight of one of the basic principles of medical ethics: "Do no harm." So, communication to the patient of the diagnosis is perceived by each of them in own way. One listens to an unfavorable diagnosis stoically, while another reports a fear about him, which in itself is an emotion dangerous to life. Therefore, the desire of the doctor to protect the patient from additional stress, fraught with a negative impact on his health, may be understandable.

The *doctor's right to "lie for salvation"* is defended mainly by supporters of the paternalistic model. Deontology, which stands on the patient's autonomy positions, categorically denies the physician's right to lie. However, sometimes the patient himself does not want to know about the true diagnosis because of a feeling of fear. This is his right - the right of a free person. But if the patient wants to know his diagnosis, the doctor in accordance with the law is obliged to inform him about this, having prepared him beforehand to perceive the information in such a way as to remove fear, aggressiveness, not to lose interest in life. Informing about the state of health, its prognosis gives the patient the opportunity to dispose of his right to life.

The *principle of voluntariness* is based on respect for the freedom of the will of the individual, which presupposes an independent decision or consent to medical manipulation or research, provided that there is awareness and no external coercion (physical, moral).

The *principle of confidentiality* manifests itself in mutual trust between the doctor and the patient (everyone has the right to decide who and to what extent he can convey his thoughts, feelings, feelings). Violation of confidentiality worsens the relationship between the patient and the doctor and makes it difficult for the latter to perform their duties. Confidentiality presupposes strict observance of medical secrets - reliable storage of information received from the patient by the doctor, anonymity of the conducted research, minimization of interference in the patient's personal life, careful storage of these data and limitation of access to them both during life and after the patient's death [5].

T. Mishatkina notes that as medicine develops and more and more people are involved in biomedical research and manipulation, the principles, conditionally speaking, of the "passive" order, assuming the care of society and doctors - doctors and researchers about the observance of ethical requirements in relation to patients who are dependent on them [6]. In this regard, the *principles of integrity, vulnerability and justice p*ut forward by the modern European community play a special role in the system of biomedical ethics [4, p.181], they also include *respect for a person as a person, the principles of charity, mercy, solidarity* [3, p. 91]. These principles are directly related to respect for the dignity of the individual and affect both the physical and mental aspects of the individual's vital activity.

Principles and norms of proper behavior of a doctor are usually reflected in the deontological codes adopted by the medical community of a particular country. In the Republic of Belarus, such a deontological code that can and should be used by doctors in their daily practice is the Code of Medical Ethics adopted by the First Congress of Doctors of the Republic of Belarus (1998) and approved by the Ministry of Health of the Republic of Belarus (1999). Knowledge of the basic provisions of the Code and constant treatment will help to form strong stable deontological stereotypes in the minds of future doctors, provide the deontological side of the professional culture of the doctor.

Patient autonomy model, according to experts such as A. Ivanyushkin, T. Mishatkina, T. Pokulenko, P. Tishchenko, B. Yudin is more effective than paternalistic, but success in its application can only be achieved by observing the professional code, publishing information about the rights of patients, and creating a social atmosphere that would facilitate therapeutic dialogue.

It should be noted that due to the complexity of the object and the subject of medical activity, for all the progressivity and democratic character of the autonomous model, situations often arise that force the doctor to act without obtaining the informed consent of the patient. Firstly, this is a situation where the patient's condition does not allow him to participate in decision-making at a time when urgent medical intervention is required (surgical patient in unconscious condition). Here the paternalistic model of behavior is more legitimate. Secondly, these are situations related to the "quality" of the patient's personality, when the decisive factor is the decrease in the level of mental and intellectual activity of the patient and, accordingly, the level of autonomy of his personality (for example, in patients in a state of alcoholic or narcotic intoxication, in psychiatric or geriatric patients institutions). Here, too, there are difficulties in the unconditional use of an autonomous model [6].

In this regard, in the event of a decrease in the level of individual autonomy, it is advisable to introduce, in our opinion, the third, a borderline

model - a weakened paternalism. This model postulates the permissibility of partial restriction of a person's autonomy in those cases when it is necessary to keep an individual with a significantly reduced level of personality from causing himself or other significant harm (suicide attempt, drug addictive hallucinations) and gain time to find out the seriousness of his intentions.

Thus, as conclusions can be noted: first, deontology was traditionally the basis of the professional culture of a doctor. Modern medical deontology includes fundamentally important moral and ethical, psychological and legal norms and principles of mutual relations between the doctor and the participants of the medical process and is a valuable guideline for the professional activity of the doctor, since he forms strong professional moral stereotypes associated with him with the performance of his professional duty, increasing the sense of his professional responsibility and dignity. Secondly, the professional-moral model of medicine today is moving away from the traditional model of medical paternalism to the adoption of an autonomous model of healing, which, in our opinion, will allow us to develop value orientations in the professional activities of the doctor, which correspond to human rights for life, autonomy and respect for its dignity. Thirdly, the basic principles and rules of biomedical ethics: autonomy of the person, informed consent, confidentiality, voluntariness, integrity, vulnerability, truthfulness, privacy, respect for a person as a person, principles should be laid on the basis of a new model of relations in the "doctor-patient" system: charity and mercy, justice, solidarity, and so on.

3.4. Moral climate of medical staff. Conflicts in the medical team

The process of medical care includes various types of relationships in the triad of "medical employee-patient-society" (information, organizational, economic, legal, ethical, etc.), as well as various types of social interactions – competition, cooperation, conflict.

Subordination, discipline and good, benevolent relationships between employees are the basis for the successful work of the medical team. Under these conditions, a healthy socio-psychological climate is ensured. Collectivism in the work of doctors determines the success in professional work.

However, the collective is often formed from people with different personal characteristics, characters, temperaments. In this regard, mutual understanding, respect, benevolence, moral support of each other, that is, the spirit of true partnership, is necessary. In the team, everyone should be guided by a sense of responsibility, be exacting to oneself and fair to others. In the process of long-term joint activity, the members of the collective work out, and the stable relations of the work colleagues are created.

Almost in every medical team both among doctors and nurses there are people with a "heavy" character, increased emotional excitability, painful

resentment, people capable of inadequate reactions, often entering into a quarrel. A reasonable tolerance for their shortcomings, a great tact is necessary. Sometimes these properties of character and peculiarities of behavior are explained by the morbid state of the employee, family troubles, some severe experiences of personal order. It often requires the friendly support of employees. You cannot create for such people the conditions of isolation from the collective, an atmosphere of hostility, as it embittered.

Conflicts in medicine, as well as in other branches, occur on *three levels of contradictions* (high, medium and low):

- health system – society;
- health facilities (administration) – medical personnel (horizontally);
- medical personnel – patients and their relatives (vertically).

Parties to conflict in medicine are:

a) in interpersonal: the medical officer is the patient; medic - the medic; employee - administrator;

b) in the intergroup: the administration of the treatment and prophylactic institution – the patient, the medical personnel – the patient's relatives, the administration of the medical and prophylactic institution (as a legal entity) – the patient (the plaintiff in court).

The subject of conflict in medicine are:

a) objective reasons (not depending on the doctor);

b) subjective reasons (depending on the doctor)

The most common ways to resolve conflicts in medical practice: a) pre-trial: the resolution of the conflict at the primary level of "doctor-patient", the head of the department, the administration of health facilities, the ethics committee; b) judicial: bodies of state jurisdiction; bodies of non-state jurisdiction-specialized arbitration courts.

The methods for resolving conflicts lead to the corresponding typical results of conflict resolution:

a) resolution of the conflict at the pre-trial level;

b) execution of the court decision.

It was revealed that conflict behavior among patients is inherent in persons of pre-retirement or retirement age, who have a low level of education, an unsettled personal life, and who have little comfortable living conditions. Among them, a significant proportion of those who, despite unsatisfactory health, are forced to work sometimes even beyond the usual norm of workload, established by specialty or age. The subjects of conflicts in medical practice often become citizens with low incomes, limiting their ability to receive paid (or partially paid) types of medical care and treatment with high-quality (and therefore effective) drugs.

4. ETHICS PROBLEMS OF MEDICAL CARE FOR PATIENTS WHO HAVE DISEASES POSING HEALTH HAZARD OF THE POPULATION, HUMAN IMMUNODEFICIENCY VIRUS AND ALSO SUFFERING FROM CHRONIC ALCOHOLISM, DRUG ADDICTION AND ABUSE

4.1. The moral foundation of medical care for people with diseases representing health hazard of the population, human immunodeficiency virus (HIV).

4.2. Ethical standards in the treatment of HIV-infected children.

4.3. Inadmissibility of discrimination and stigmatization of people living with HIV / AIDS.

4.4. The problem of the fear of AIDS and requirements of medical ethics.

4.5. The importance of patient confidentiality.

4.6. The voluntariness and anonymity of medical examination of persons for the presence of diseases representing health hazard of the population, HIV.

4.7. Professional risk of health workers.

4.8. Legal and social protection of people living with HIV / AIDS.

4.9 The peculiarity of medical activity and the moral component of a modern doctor.

4.10 Ethical and legal problems of modern psychiatry.

4.11 Ethical problems in narcology.

4.12 Conceptual model of the professional culture of the doctor at the present stage: structure, content.

4.1. The moral foundation of medical care for people with diseases representing health hazard of the population, human immunodeficiency virus (HIV)

HIV infection is a slowly progressive viral disease of the immune system leading to the weakening of the immune protection against tumors and infections. The stage of HIV infection, in which because of lower immunity in humans appear secondary infectious or neoplastic disease, called acquired immunodeficiency syndrome (AIDS). The disease was first identified in USA in 1981, although later reports of cases it occurred earlier were published by the media. In 1983, a Frenchman, L. Montagnier, and independently, the American R. Gallo identified the virus that caused AIDS. The dispute between them about precedence, ended with a compromise, and most importantly – in the course of this dispute, the virus has now recognized all over the world the name "human immunodeficiency virus" (HIV).

AIDS is the syndrome of acquired immunodeficiency is isolated into an independent nosological unit, although in fact AIDS is one of the stages of

HIV infection. The causative agent of the disease was established in 1982-84. American Robert Halo and Frenchman Luke Montagnier.

The AIDS patient becomes "leper" and "outcast" in the eyes of others. Stigma is the assumption that HIV-infected people are dangerous to society. For health workers, the challenge created by the unique nature of AIDS is largely concerned with their role in dispelling the myths and stigmas that have arisen around this disease. In addition, stigma is often a consequence of violations by health officials of confidentiality rules.

HIV infection posed an acute problem of doctors' refusal in many countries of the world to help people infected with HIV. The motive of such refusals by medical workers is their personal safety. This problem has not yet found its adequate solution. A person with AIDS, like any other patient, has the right to confidentiality. However, there are serious problems when he comes to any party - a sexual partner, for example. If there is a real threat of infection, and the patient refuses to communicate to the partner, the doctor is instructed to violate the confidentiality by notifying the patient in advance.

In the case of HIV/AIDS, there is the problem of implementing the principle of "Do good!". In a specific clinical situation, the implementation of the "Do good" principle does not focus only on HIV-infected people and their treatment, but it includes the issues of the necessary prevention of HIV infection in people who make up the nearest circle of the patient. Another important aspect of the moral and ethical issues of HIV/AIDS is the issue of the advisability of providing assistance to HIV-infected and AIDS patients. This issue arises not only among medical professionals who are professionally aware that the treatment of AIDS does not currently lead to the desired result. This issue is raised by insurance companies, economists and members of the public. In this regard, the issue of implementing the principle of fairness towards HIV-infected and AIDS patients is acute. It is important to emphasize the legal and moral aspects of a fair attitude towards HIV-infected and AIDS patients. In the legal (formal) aspect, this category of patients, in accordance with international law and national legislation, has equal rights to health protection and medical care in comparison with other citizens. In the moral aspect, when it comes to equality based on the recognition of every person infected with HIV and AIDS, there is a differentiated approach to the identity of the HIV-infected and AIDS patients in the medical community.

The source of the contamination is HIV infected people at all stages of the disease. *There are 3 ways of HIV transmission*:

- contact (sexual);
- parenteral (through blood, syringes, needles, cutting tools, etc., contaminated blood containing HIV);
- vertical (from mother to fetus).

Risk factors: drug addiction, an anti-social lifestyle, blood transfusion, birth from HIV-infected mother, sexually transmitted diseases.

The majority of HIV-positive people is injecting drug users. In Belarus in the structure of the HIV-infected people men are mostly dominated - about 70%.

Contributors high risk of infection include:

- persons representing sex-services;
- persons practicing unprotected sex;
- persons who have professional contact with blood;
- drug users (even a single sample of drugs can lead to HIV infection).

It is also possible to be infected HIV-infection at implementation of different tattoos, if sterility of realization of manipulation is not observed. Possibility of transmission of virus in the way of life through the infected shaving things and other sharp objects is not eliminated.

Many traditional principles and norms of bioethics are tested specifically with regard to the application to HIV infection.

HIV (human immunodeficiency virus) belongs to the group of retroviruses, i.e. viruses whose reproductive genetic material is not DNA, as in most cells, but RNA.

Several groups of high-risk HIV infection can be distinguished:

1) homosexuals and bisexuals;

2) drug addicts using intravenous drug use;

3) prostitutes;

4) patients and persons occasionally undergoing blood transfusions. Given that among people living with HIV who are leading lifestyle, which traditionally causes negative public evaluation, health service workers often feel that AIDS is a punishment for "misconduct". Having such an installation, medical workers begin to differentiate patients from different risk groups, which often creates an ethical conflict. Clearly, such a differentiation of patients contradicts the principle of justice.

The basic ethic problems related to distribution of HIV-infection are:

- equal access to treatment;
- receipt of the informed consent to diagnostics of infection;
- observance of confidentiality both in connection with providing of medicare and in different social situations;
- stigmatization and discrimination of people living with HIV/AIDS.

The diversity of moral and ethical issues related to HIV-infection is determined by the following factors:

- AIDS is a disease with extremely high mortality;
- HIV-infection has become pandemic, i.e. its distribution is not limited to any geographical nor national or cultural boundaries;

- the etiology of AIDS, in most cases, is associated with intimate aspects of human life, with human sexuality, as well as such forms of deviant behavior as drug abuse;

- natural man's fear of an incurable disease often become a source of inadequate behavior of many people in relation to AIDS;

- the high cost of treatment of HIV-infected and AIDS patients in combination with the steady increase in the number of persons in need of such treatment, leads to disputes on the themes of social justice, the optimal allocation of health resources, which even in the rich countries is always limited;

- almost all the most important issues of modern medical ethics (maintaining medical confidentiality, respect for the individual autonomy of the patient, etc.) require specifying, in-depth analysis in relation to HIV-infected and AIDS patients.

Morality (from the Latin. moralis – relating to the disposition, character, way of thinking, habits) – a set of principles and norms of behavior, values, and ideals that govern the relationship between people. To the higher moral values that specify the very General guidance of the medical profession can be attributed to – *goodness, compassion, mercy, freedom, duty, conscience, justice, etc.* In the context of bioethical knowledge life takes on special meaning as the value and purpose of healing.

In addition to the main ethical problems there are also many *specific ethical situations* encountering in everyday medical and social practice in interaction with HIV/AIDS. For example, what additional ethical obligations to patients appear at the health worker if he is HIV-positiv? As a doctor would do, starting treatment if he can not control the results with laboratory tests, or thinks that the patient will be unable to follow the prescribed treatment regimen? Whether is it necessary to recommend to women with HIV / AIDS do not have children, because of their possible contamination? Should I, as a physician, make recommendations on the treatment of the patient, if I am not competent in this, but there are no other specialists able to give more detailed advice? If I am a physician of partner of my HIV-infected patient, whether in this case, should I tell her (him) about the risk of infection? Answers to these and other questions cannot yet be achieved today, but, nevertheless, they point to the need for active work in this direction.

The moral foundations of medical care:

For example, the physician's attitude towards HIV-infected individuals representing marginalized groups particularly well demonstrates the importance of ***the principle of "do good"***. In accordance with this principle, the moral duty of the medical worker is to provide professional assistance, caring and compassion to such persons, and not an assessment of their lifestyle. Another requirement of biomedical ethics - the inadmissibility

of the part of the physician, nurse, clinical psychologist, etc. imposing their worldview, their religious and philosophical views, their opinions to the patient. ***Respect for patient autonomy*** – is a respect for his system of values, characteristics of his personality.

There are *7 main aspects of autonomy* to consider in the implementation of this principle in the practice of medicine:

1. respect the patient's personality;
2. provision of psychological support to the patient in difficult situations;
3. giving him the necessary information (on health status and about the proposed medical measures);
4. a choice of alternatives, for example, to completely abandon the use of the drug or to obtain a substitute appointed by the doctor in the form of maintenance therapy;
5. patient autonomy in decision-making;
6. ability to monitor the patient over the course of the study or treatment;
7. patient involvement in medical attention process ("therapeutic partnership").

Excessive medical care for the health of HIV-infected persons and interference with family and personal life also violates the privacy of the patient, that naturally leads to the deterioration of cooperation and effectiveness of the treatment results.

To ensure equitable access to AIDS treatment has become an acute problem in many countries. Exactly through equal access ethical *principle of justice* is realized. As the primary lesion groups are primarily injecting drug users and homosexuals, and these groups are characterized by low availability of the application of the approaches of traditional medicine (clinical examination, medical check-ups, etc.), assistance was focused on "normal" HIV-positive. At the same time these groups of infected people received HIV earlier than the others, and so they appear before the manifestation of AIDS, requiring specialized antiretroviral therapy. Difficulties of equal access to treatment are connected with the prejudices of doctors that compliance with prescribed treatment scheme will be problematic for addicts, but continued receiving concomitant drugs significantly reduce the effectiveness of therapy. In the past, these problems do arise, but since that time, as in some countries began to apply the substitution therapy and carry out actions on psychosocial support injecting drug users, treatment effectiveness has become comparable with the results of the "ordinary" people.

Recent studies show that the inclusion of the needs of vulnerable and affected population groups increases their involvement in treatment and significantly improves its results.

4.2. Ethical standards in the treatment of HIV-infected children

As of January 1, 2017, in the Republic of Belarus 22 218 cases of HIV infection were registered. During 2016 2391 HIV-positive was identified (2015 - 2305). Another problem is the appearance of children with HIV. The diagnosis of "HIV" is confirmed 291 child born to HIV-infected mothers (1987 – 2017).

According to the UN and the WHO report, published at the end of 2009, the total number of HIV-infected people in the world amounted to 33.4 million, a number of children under 15 years of them - 2.1 million people.

Increasing the number of HIV-positive women of childbearing age will inevitably lead to the annual increase in the number of children they bear. Transmission of HIV from mother to child is possible during pregnancy, childbirth and breastfeeding. Approximately 99% of children with HIV between the ages of 0 and 15 years are infected by their mothers. Only about 1% of the children were infected through injecting drug use and sexually.

According to statistics, HIV is spreading most rapidly among young people under the age of 25 years. One in four HIV-infected person is under the age of 21 years. The risk of an infected child born to HIV-positive women is 25-40%.

Adolescence can be considered as a risk factor for HIV infection. Risky behavior, injecting drug use and unprotected sex among adolescents lead to the spread of not only HIV, but also a variety of other infections transmitted sexually. It requires active preventive work with children and adolescents for the prevention of disease. HIV-positive children would receive the necessary medical, social and psychological assistance:

1. Voluntary HIV counseling and rapid testing.
2. Ensuring access to treatment and care for children living with HIV / AIDS.
3. Drug rehabilitation of drug addicts.
4. Social and psychological rehabilitation, training, adaptation and living arrangements.
5. Prevention of HIV, hepatitis and sexually transmitted infections in the street environment.
6. The protection from discrimination and respect for the rights of children living with HIV / AIDS and vulnerable groups.

HIV infection is not an obstacle for being in child care in conjunction with uninfected children. Household contacts of HIV-infected child are safe.

Every child, regardless of him HIV status, the presence of other diseases and physical "defects", is especially a child, he needs love and care. A child with HIV infection with appropriate special treatment can live and

develop in much the same way as his peers, attend kindergarten or school. HIV-positive children are often social outcasts, confined to communicating with their peers. They begin to feel a sense of worthlessness, inferiority and loneliness. Storing medical confidentiality in the case of HIV infection in a child is of even greater social significance than in the presence of malignancy, as surrounding and peers see in this child an infectious patient. It forces parents to carefully hide the presence of HIV infection in children, depriving them of health service and social support. Although children with HIV infection do not pose a danger to others, in some cases it is necessary to limit the contacts of those patients with peers. The aim of the doctor is a manifestation of a careful, sensitive, humane attitude in the treatment of children with this disorder. The physician must understand the subtle psychology of the child and his parents.

4.3. Inadmissibility of discrimination and stigmatization of people living with HIV, AIDS patients

Discrimination (Latin *discriminatio* – «distinction», «infringement») – 1) restriction or deprivation of rights of certain categories of citizens, for any signs; 2) a negative attitude, denial and restriction of rights, and violence, and all manifestations of hostility towards those who have dangerous "evil" characters ("stigma").

Stigma – 1) in ancient times, the brand, applied to the body of a slave or criminal; 2) the effects of a certain shortcut (diagnosis), manifested in the prejudiced attitude of the society to its bearer.

Stigmatization (from the Greek *στίγμα* – «Tag, brand") - branding, application "stigma" hanging social labels - linking of any quality (usually negative) with an individual or a lot of people, is an integral part of many stereotypes. Stigma can lead to discrimination that is to action, limiting the right of any group.

HIV infection since its inception has created a lot of problems of ethical and legal issues in the society. This is due primarily to the low awareness of the population about infection, as well as the negative influence of the media.

In the case of HIV / AIDS since the epidemic began, the public interest have been put in the first place, which led to proposals for the isolation of HIV-infected, their compulsory treatment, other forms of discrimination (dismissals, the prohibition to stay in the kindergartens and schools for children with HIV / AIDS, excessive health restrictive measures). And depending on the infection routes (injection, and homosexual sex), the ratio of health workers and the community to HIV-infected is being stigmatised more than in the case of infection during medical manipulations or at birth. Also, many countries do not provide treatment for AIDS (it is

carried out there by international aid), and mostly sanitary-epidemiological measures aimed at protecting the rest of society from possible infection and its carriers are financed in these countries.

The phenomenon of the fear of AIDS raised the issue of social protection of HIV-infected and non-discrimination in these patients that is not uncommon among practitioners. There are many examples when unethical behavior of health workers initiated discrimination, and even direct violence against the virus carriers or AIDS patients.

In the first documents adopted by the WHO, the World Medical Association and other international organizations in connection with the growth of the AIDS pandemic, specially allocated requirement to prevent *discrimination against HIV-positive people* took one of the central places. It is important, however, not only a moral condemnation of discrimination against AIDS patients, but also the creation of appropriate safeguards.

It is possible in this connection to recall the moral obligation of a physician, contained in the "Geneva Declaration" of the World Medical Association (WMA): "I will not allow considerations of gender or age, illness or disability, religious, ethnic, national or racial affiliation, political ideology, sexual orientation or social status to come between the execution of my duty and my patient."

Discrimination against AIDS patients, ignorance and prejudices inherent not only to the population, but also of the health professionals - all this ultimately has a negative impact on the epidemiological situation, the pace of the spread of infection. Discrimination of HIV-infected and AIDS patients not only violates human rights but undermines the fundamental principles of public health. It can provoke an infected person or patient the feeling of revenge, able to turn him into a willful deliberate spreader of infection. If a person has realized his doom, a feeling of revenge can be particularly fierce. It should be recognized that protecting the rights and dignity of HIV-positive person, the society protects itself.

4.4. The problem of the fear of AIDS and the requirements of medical ethics

The fear of AIDS - socio-psychological phenomenon (similar to "cancerophobia", "radio-phobia", etc.), the most severe form of stigma, people panic fear of the disease and HIV carriers.

The inevitable reaction of most people on the acronym "AIDS" is fear of infection, dying, death, impotence medicine and society as a whole, incapable, by popular opinion, to oppose AIDS anything effective. One of the paradoxical manifestation of the fear of AIDS is the unconscious desire of people to "forget" about the threat, to turn away from it. This is manifested as in irresponsibility, constantly impending infection behavior as in underestimating the problems with the public authorities.

Failure of physicians and other members of the medical profession to provide assistance to HIV-positive people is hardly the any most intense in terms of medical ethics, problem. Conducted in the early 1990s in the US study revealed that by denying care to people with AIDS, doctors referred to the lack of specific training, fear of infection, aversion to homosexuals, drug addicts and others in the "high risk groups" as well as fear to reject other patients. Such refusal do not respond not only standards of medical ethics and ethics in general, but also the requirements of the law. Refusal to care for people living with HIV / AIDS is a ***gross violation of professional medical ethics!***

In the minds of HIV-infected people the fear of stigma and discrimination is often in the foreground. Initially, in the Western countries, AIDS was spreading among the so-called "marginal social groups" - homosexuals, drug addicts, prostitutes. Strict moralists have repeatedly stated that AIDS is "God's punishment" for "the sin of homosexuality", "sport sex", "sex tourism", etc. The negative attitude of society to the members of these marginalized groups of inertia was transferred to all HIV-infected persons and their stigmatization multiplies with the growing fear of AIDS.

It is appropriate in connection with the problem under discussion to compare AIDS to cancer. The diagnosis of cancer is perceived mass consciousness, and the individual as a death sentence. The diagnosis of mental illness often stigmatizes the person. AIDS patients tend to experience both: awareness of incurability, doomed to death is aggravated by emotional isolation, hostility towards them from the society.

More recently, the media were full of reports of violence facts on AIDS patients, their expulsion from their homes, creating around them "emotional ghetto," etc. In dealing with HIV-positive or AIDS patients, the doctor has to face not only with clinical reality, but also related with the disease myths and prejudices, the distribution of which is largely generated by the ignorance of many people. He must have the courage to stand up to these manifestations. Hence the special *significance of medical confidentiality* in cases of HIV infection derives.

4.5.The importance of medical confidentiality

"Medical secrecy" in the form of confidentiality rules is fixed in many codes of ethics, starting with the "Hippocratic Oath", as well as the Laws of the Republic of Belarus, which protect the right to privacy, and even introduce penalties for its violation. In ancient India there was a saying: "You can be afraid of your brother, mother, friend, but a doctor - never."

Along with the denial of care for HIV-infected and AIDS patients flagrant violation of professional medical ethics is the release of the diagnosis. Disclosure of medical secrets by physicians often was a manifestation of the same fear of the AIDS in society, i.e, health workers not

only violated the legal rights of their patients but also themselves become agents of moods of fear of AIDS. We are talking about the obligations not only of the doctor and any other health workers and officials to whom this information was transferred or obtained during the performance of their duties.

The relationship between doctor and patient are not equal. The doctor has a great responsibility, and at the same time he is a strong point. Special relationship requires a patient, if he wants effective treatment, to disclose a lot of information about yourself, putting yourself in a vulnerable position. To protect the patient the Institute of medical confidentiality is created. Feature of medical confidentiality is that doctor of the patient is known not only medical information, but much of that disease has nothing to do. Therefore, doctors are carriers of variety sensitive information. It is very important that the Hippocratic Oath, equally, and all subsequent codes of ethics, insists that the doctor must maintain the privacy of all information, not just the one that came from the patient, and applies only to the disease.

The question of the participation of the patient in making medical decisions is particularly acute. In this case we are talking about prior informed consent of the patient to medical intervention. Now it is has not only moral force, but also a legal norm. As the patient as the doctor have the right that everyone should know.

If *the rule of truthfulness* ensures transparency in the doctor-patient interaction, *the rule of confidentiality* is designed to protect the doctor-patient system from unauthorized access from the outside.

The subject of privacy is: the fact of seeking medical help, the diagnosis of disease, health status, prognosis, and all the information that a medical worker receives in the course of the survey, while listening to the complaints. Non-medical information about the patient and his family, which became known doctor, should be confidential. From examination and questioning of the patient's doctor must find out for whom the patient recognizes the right to have access to information concerning his health. All these factors should be taken into consideration, being guided in practice the rule of confidentiality.

The law of conservation of medical confidentiality is often violated. Inpatient cards are not always properly stored and can be accessed and the discharge summaries are often printed technical staff members who have access to medical conclusions. People usually tend to keep secret malformations in the child, hereditary diseases, mental retardation, and mental illness in family members. The preservation of medical secrecy is obligatory if a teenager (especially a girl) confided in the doctor about the onset of sexual activity without informing parents.

The narrow range of situations when information of medical secrecy can be disclosed without permission of the patient is strictly defined by the law:

1. We are talking about the incompetent, i.e. those individuals who are not able to express their will because of impaired consciousness, a minority.
2. The presence of the threat of the spread of infectious diseases and mass poisoning.
3. The presence of a physician to suggest that the damage to the patient's health was the result of illegal actions.

Moral standard of confidentiality is the key to the acquisition of confidence, which is very important in medical practice.

How to resolve the situation required the disclosure of medical confidentiality? The situation should be discussed in detail with the patient; it is useful to discuss such problem with colleagues. It is possible that the patient's opposition to the transfer of information due to the fact that he either underestimates the danger in the circumstances, or exaggerates the difficulties that may arise as a result of his disclosure. In cases where the patient can not convince, the physician must decide himself and carry the entire burden of responsibility for the decision.

Particular difficulties arise when people with HIV do not want to disclose this fact to their sexual partners for fear of breaking off relations. At the same time warning of the partner by physician, made with the good in order to prevent the risk of infection, violate the rule of confidentiality. In this case the belief in the need to inform the partner could be the best solution.

Significant problems arise from the progressive division of medical workers. Therefore, storage of patient confidentiality becomes a moral obligation not only to the individual doctor, and a medical team.

4.6. Voluntariness and anonymity of medical examination of persons for the diseases those are dangerous for public health, HIV

According to the Law of the Republic of Belarus “On the Prevention of the Spread of Diseases Posing Danger to Public Health, the Human Immunodeficiency Virus”, dated 7 January 2012 No. 345-3:

Medical examination is the study and assessment of the patient's health performed by a medical specialist in the process of providing medical assistance in order to determine whether the patient has a socially dangerous disease, HIV, and to determine whether he or she needs medical assistance.

Voluntary medical examination is a medical examination conducted at the request of the patient, and in cases stipulated by legislative acts - with the consent of their legal representative in the order established by the

legislation on public health. A voluntary medical examination can be conducted anonymously.

Mandatory medical examination is a medical examination, which is mandatory for certain categories of persons, as well as persons whose list is determined by the Ministry of Health of the Republic of Belarus.

Compulsory medical examination is a medical examination of persons for whom there are sufficient grounds to believe that they have a socially dangerous disease, HIV or if they evade treatment, without their consent or without the consent of their legal representative (carried out by public health organizations on the basis of the conclusion of the medical and consulting commission of the state public health organization about the necessity for compulsory medical examination and with the sanction of the prosecutor).

State policy in the field of preventing the spread of socially dangerous diseases, HIV is aimed at:

− creation of conditions for the preservation, strengthening and restoration of public health;

− reduction of the population’s incidence rate of the socially dangerous diseases, HIV;

− prevention of mother-to-child transmission of HIV during pregnancy, childbirth and the post-natal period;

− increase in life expectancy and decrease in mortality of people with socially dangerous diseases, HIV;

− identification of socially dangerous diseases, HIV in the early stages;

− formation of the population's knowledge on the problem of socially dangerous diseases, HIV and skills of safe living;

− ensuring the rights of people with socially dangerous diseases, HIV;

− ensuring the rights of persons for whom there are reasonable grounds to believe that they have socially dangerous diseases, HIV;

− ensuring the rights of persons providing medical care to patients or participating in the organization of its provision;

− ensuring the priority of preventive measures.

The serological test for the presence of antibodies to HIV in humans has become widely available since 1985. Typically, screening involves routine testing within the entire population or individual groups within populations. The incubation period for HIV infection is 1-3 months (on average 6 weeks, sometimes the latent period of the virus circulation can reach three years). The possibility to pass a test for the presence of antibodies to HIV should be provided to everyone. Tests for detecting antibodies are quite sensitive. Sometimes, in the presence of a number of factors, the test results can be false-positive. This means that the test reacts to antibodies

similar to antibodies to HIV. Therefore, the first positive result should always be confirmed by other tests.

In modern society, testing can be voluntary and mandatory. In case of voluntary anonymous testing the patient is registered under a number; it is permissible to specify the demographic information (age, sex), but neither the name nor the address of the subject is entered in the documents. The Republic of Belarus provides access to all who apply for free, including anonymous, HIV testing.

For a long time, compulsory (not taking into account the desire) HIV testing (screening) was practiced, and to date it has been preserved for prisoners, military personnel, certain groups of medical patients, and for certain types of work, which raises controversy. Thus, the principle of obtaining informed consent for this procedure is violated, as well as the "right not to know" one’s diagnosis. In many countries, mandatory screening for HIV of blood, sperm, other donor tissues and organs has been accepted.

In many situations, the principle of autonomy is observed formally: the practice of pre-test and post-test counseling (informing), as a rule, is not carried out, and after receiving "positive" results, the patient is informed immediately after the fact and directly: "you have HIV". It ignores the fact that the diagnosis message will cause any person a psychological shock and negative emotional experiences, and the person needs support, not words: "what did you want, using drugs (having sex with men, for money or unsafe)". The grossest breach of professional ethics will be a communication to the patient not preceded by a competent counsel about a positive test result, not yet confirmed in the re-analysis. A frequent excuse for not receiving an informed consent is that patients (“them being drug addicts, homosexuals, prostitutes”) are threatening the health of others with their behavior, and therefore any coercive measures can be applied to them. The need to recognize that in some situations the harm cannot be eliminated completely and it should at least be reduced. The last position forms a basis for the so-called harm reduction approaches that do not attempt to destroy drug use, homosexuality, or risky sexual behavior, but aim to reduce the consequences of this behavior and educate people how to live with it less dangerous to themselves.

In the Republic of Belarus, an HIV test is carried out in accordance with the principles of confidentiality and respect for human rights and freedoms. The state healthcare system of the Republic of Belarus ensures maximum availability of pre-test and post-test counseling and testing for HIV infection. Taking the test, including anonymously, is possible in the procedural office of any general health organization or HIV/AIDS prevention department of the Republican Center for Hygiene, Epidemiology and Public Health. Every year during December, as part of the World AIDS Day, rapid HIV testing is conducted. For the most HIV-vulnerable groups of the

population in the country, additional conditions have been created for testing and counseling on the basis of anonymous consultation stations of any healthcare organization of the Republic of Belarus.

4.7. Professional risk of medical workers

Since the first years of the spread of HIV infection, studies have been conducted to determine the extent of such occupational risk. A special study showed that the risk of infection of a surgeon from an infected patient is 1: 4500. In general, the risk of infection for a surgeon using protective equipment is the same as in heterosexual sexual contact with an infected partner when using a condom. Other calculations showed that the odd of occupational infection of a medical worker in the case of needle sticking is 1 out of 250.

In recent years, the risk of infection with accidental sticking with a needle or with a cut with a scalpel contaminated with HIV is estimated by some authors at 1%, by others at 0, 3%. For comparison, it should be emphasized that the risk of contracting the hepatitis B virus with an accidental needle stick is 6% to 30%. The risk of contracting HIV by contacting the mucous membrane or the affected area of the skin with infected blood is very low, but quantifying it is much more difficult. Given that the world still knows dozens of cases (rigorously proven) of occupational HIV infection among doctors, it can be said: the risk is minimal, but it is real.

The problem of occupational HIV infection among medical workers includes not only an assessment of the emerging real danger to their health and life, but also measures to minimize the danger and, finally, the moral aspects themselves − the attitude towards the risk of the doctors themselves, their patients and society as a whole.

Measures to reduce the risk of occupational infection, in turn, have medico-technical and socio-organizational aspects. It is known that the precautions recommended to prevent infection with the hepatitis B virus are sufficient to protect against HIV infection (the latter is much less stable than the hepatitis B virus). Despite this, WHO in 1983 published additional recommendations on compliance with safety measures when handling materials containing blood (for example, the prohibition of sucking liquids into the pipette orally, the use of disposable instruments, etc.). In 1988, WHO published “Precautions for working with blood and other body fluids”. Here, in particular, it is said that the treatment of blood and other liquid components should always be as if they were infected.

In the socio-organizational plan, a system of monitoring, recording cases of possible and actual HIV infection of medical staff should be applied in all medical organizations.

If an infected doctor or nurse remains in a clinical work involving the need for invasive interventions, the problem arises: should they inform of

their being infected the patients to whom they are conducting such interventions? In the modern literature various variants of the answer to this question are described. So, the American ophthalmologist informed his patients about his infection, giving them the freedom to choose whether to get treatment from him or to seek help from another doctor. Another example of two HIV-infected surgeons, one of them for some time continued to work as a surgeon, trying to apply increased protective measures to his patients (in particular, he worn several gloves before doing surgery), but then he abandoned his medical activity, while the other immediately changed his job.

Another collision occurs when, for example, the HIV-infected health worker, continuing clinical practice, allows negligence, for example, the penetration of his blood into the blood or the mucous membrane of the patient. In this case, it is his professional and moral duty to inform the patient and, of course, to provide him with the necessary assistance.

4.8. Legal and social protection of persons infected with HIV, AIDS patients

The rights of citizens to health protection (or in the sphere of medical activities), regardless of their HIV status, are considered as a set of provisions contained in international and national regulations that guarantee citizens health protection and provision of medical care in the event of a disease. The most significant international document - the Universal Declaration of Human Rights (1948) - proclaimed the equality of all in front of the law, protection from any discrimination, arbitrary interference with privacy, as well as the right to social security and services, medical care in the event Illness or disability of all without exception.

The Constitution of the Republic of Belarus, emphasizing that a person, his life and health are recognized as the highest social values, guaranteed in Articles 45, 46, 47 all of the listed rights. People living with HIV / AIDS are guaranteed the rights stipulated in the Constitution (the right: for health and life protection, for free treatment in public health organizations, for ecological and sanitary-epidemiological well-being, etc.)

Social relations related to HIV / AIDS, are regulated by separate articles of the Laws of the Republic of Belarus "On Health Service", "On Sanitary and Epidemic Well-Being of the Population", "On State Benefits for Families Raising Children", "On Blood Donor and Its Components"; normative documents of the Council of Ministers, various Ministries (health, labor and social protection, education) and departments.

The Healthcare Law of the Republic of Belarus provides for the constitutional rights to health protection to be specified and regulated in detail: the right of HIV-positive citizens to health service; Provision of affordable medical care. The country provides with universal access to HIV prevention, treatment, care and support.

Persons who have been discovered to have contracted the HIV infection are warned by health authorities and organizations in writing about their having such diseases, about the need to comply with precautions on the nonproliferation of these diseases and on criminal liability in accordance with the current legislation for deliberately posing a risk of infection or contamination of another person.

HIV-infected people, including women and children, enjoy all the rights and freedoms, like other citizens of the Republic of Belarus. It is not allowed to dismiss them from work, refusal to work, refusal to admit children to children's institutions, as well as infringement of other rights and restriction of legitimate interests. They have the right to social services and support. According to the Law of the Republic of Belarus "On State Benefits for Families Raising Children", material support is provided for HIV-infected children under the age of 18.

The organization of medical care for people living with HIV is carried out in accordance with the principle of confidentiality and respect for human rights and freedoms.

People living with HIV are also provided with prevention services in the areas of reproductive health, family planning, contraception. Access has been ensured of HIV-infected pregnant women to drug prevention of mother-to-child transmission of HIV, which reduces the risk of HIV transmission.

Donors' means are also channeled into the people's access to information, quality prevention, treatment and care.

Social protection of HIV-infected people implies prohibitions on limiting their rights. This applies primarily to obtaining medical care. The infected have the right to receive it in any organization on a par with healthy people. At the same time, infected persons are obliged to notify doctors and other medical workers about their diagnosis. All HIV-positive patients, if they have indications for specific treatment, receive free antiretroviral therapy in Belarus. Having started treatment with antiretroviral drugs in due time and following all the doctor's instructions, people living with HIV can live a long and fulfilling life.

Syringe and needle exchange programs have demonstrated the effectiveness in reducing the spread of HIV infection, along with providing means for safer sex practices, educating people for prevention strategies on the "peer to peer" principle (because the traditional "specialist-needy" model in many situations demonstrated its low efficiency), social work, support groups. The employment of patients with the immunodeficiency virus should be carried out without obstacles. AIDS-infected young people can enter any educational institution. The administration of universities and colleges is not entitled to refuse an applicant to file documents, and also to create any obstacles.

The HIV is a socially significant disease. Social support for an HIV-infected family, or rather families with infected children, is also carried out according to the norms of the current legislation. Parents in this case have the right to free stay (with provision of beds and meals) in medical organizations.

4.9 The peculiarity of medical activity and the moral component of a modern doctor

The peculiarity of medical activity is manifested in a particularly pronounced (in comparison with other professions) *corporatism*, manifested in collegiality, rather strict subordination, "closeness" of the medical community for "uninitiated", a special kind of symbolism and paraphernalia.

*Collegiality i*s an integral feature of medical practice insofar as, due to the complexity of the object of research, many medical problems, especially in modern conditions, can be solved only with the help of a competent council of colleagues, a consultation or in a joint work requiring openness to interaction, respect for the opinion of colleagues, tolerance to their personal characteristics.

"Closeness" of the medical community for the "uninitiated" as one of the parties to corporatism is manifested primarily in the fact that physicians are inclined to "covert" communication, interaction that is incomprehensible to the outside observer (they use professional jargon, slang widely). The activity of medical workers is built on the basis of special knowledge, inaccessible to the majority.

Increased neuro-emotional stress, high responsibility and personal risk, physical and emotional overload - all this is also a specificity of medical work.

Medical activity is *multifunctional*, it covers all fields of medicine: diagnostics, treatment, prevention, pathology, sinology, rehabilitation. It is unlikely that any other profession has such a vast object of application of its forces.

Scientific and technological progress has led to the emergence of a number of new moral problems in the field of medical ethics and deontology, in particular, concerning the relations between physicians among themselves, which significantly affects the effectiveness of medical care. The scientific and technological revolution and specialization in medicine dramatically increased the number of doctors and average medical workers involved in the treatment and diagnostic process. Therefore, the importance of cooperation between them increased. At many scientific forums devoted to the problems of medical ethics and deontology, the issue was discussed that medical equipment, equipment, numerous laboratory tests removed the doctor from the patient and depersonalized the patient. Against the backdrop of progressive specialization and improving the technical equipment of medicine, one can lose not only the patient's holistic perception, but also the

interest in him as an individual. This phenomenon was called dehumanization, or "veterinary" medicine. The possibilities of psychotherapy worsen, often there are situations when the illness is treated, but not the patient. All this creates prerequisites for violation of the original principles, which serve as the basis for medical activity. In such conditions, the patient's need for a heartfelt attitude to his doctors has increased even more.

The peculiarities of medical activity create specific requirements for the moral and psychological qualities of the doctor, which are absent in relation to representatives of other professions (forestry specialist, engineer or agronomist). Due to its specifics, considered above, the profession of a doctor requires all the best human qualities. The core, the priority direction of the formation of the physician's personality, as the well-known humanist doctor A. Schweitzer believed, is certainly the emergence of a highly moral personality.

It is difficult to list the whole complex of qualities of a good doctor and a person. In our opinion, *the most important professionally necessary qualities of a doctor* are the following:

• the ability to respect and sympathize with the patient;

• enthusiasm for their profession, selflessness, readiness for self-sacrifice for the sake of professional duties;

• a high sense of responsibility for the results of the activity, since the most precious is entrusted to the doctor - the life, health and well-being of people;

• diligence, compulsion, pedantry in everything related to the medical-diagnostic process and the patient, his relatives and loved ones; these qualities form the authority of the doctor among patients and colleagues;

• willpower, which helps the doctor to control himself, to pull himself together;

• professional courage, the presence of developed intuition and determination, which can only be exercised with full knowledge: only those who are sufficiently prepared for all kinds of accidents are entitled to take risks, they do not panic and coolly make decisions;

• independence, adherence to principles, the fidelity of the doctor to deontological principles, the ability not to forgo them under any circumstances;

• tolerance, tolerance of culture, religion, character, habits, opinion, whims and even hostility of the patient;

• self-respect, expressed in competence, tact, goodwill, lack of arrogance;

• collegiality, goodwill, lack of selfishness;

• intolerance of negligence and dishonesty of colleagues;

• high level of communicative competence;

• professional medical observation, allowing you to see, remember and from a medical point of view to assess the slightest changes in the physical and psychological state of a person;

• developed medical reflection, self-criticism;

• diligence;

• belief in the saving mission of medicine and its purpose; optimism, even when the medicine cannot return the patient full health.

The above-listed professionally significant qualities of a doctor are considered, on the one hand, as necessary for the successful implementation of his work activity and sufficient for its positive prediction, on the other – as the moral and psychological basis of the medical subculture.

4.10 Ethical and legal problems of modern psychiatry

The fundamental problems of bioethics turned out to be extremely close in their content to the moral and ethical dilemmas that arise in the study of problems of psychiatry. A special role throughout the history of psychiatry has been played by the dilemma of paternalistic and non-paternalistic approaches, which is "cross-cutting" for all bioethics. The paternalistic model of the relationship between the doctor and the patient assumes that in the conditions of healing, the health and life of the person are undoubtedly priority values, that the ethical position of the doctor unequivocally takes into account that the "Good of the sick is the supreme law" and that the physician assumes the responsibility for making clinical decisions. The non-paternalistic model of the doctor-patient relationship is based on the priority of the patient's moral autonomy, so the key category of this approach is the category of patient's rights.

The difficulty of the psychiatrist's work is that he often finds himself in ethically contradictory situations where it is difficult to follow the provisions of the code of ethics. Among the most common ethical dilemmas in psychiatry are the following:

- involuntary hospitalization and treatment for people with deep mental disorders (psychiatrists recognize that the criterion of immediate danger cannot be the only reason for this, because without treatment there remains a group of patients who, due to their mental disorders, are unaware of the need for treatment);

- confidentiality (its rules are violated in case of increased risk to the life of the patient or other people (suicide, aggressive actions), criminal acts (violence, corruption, incest) that are committed over minors; involuntary hospitalization of the patient due to the severity of his mental state; in serious crimes);

- the principle of informed consent (the consent of the patient should be voluntary and conscious, while receiving information about the nature of

the patient's mental disorders must occur in a form accessible to him and with regard to his mental state, it is supposed to obtain prior consent before starting treatment, as well as observance of the patient's rights on refusal of treatment with the exception of cases provided for in legislation);

- choice of paternalistic or non-paternalistic model of doctor-patient relationship (cases when a patient has a disability to reason about a disease, ability to adequately assess the risk and benefit of treatment);

- the principle of "do no harm" in psychiatry finds expression in the choice of the "least restrictive alternative" (the harm that can accompany in the provision of psychiatric care to the patient, experts see in the following: coercion (a wide range of measures on the part of the doctor), social restrictions and prohibitions for to the mentally ill, the alienation of the mentally ill from modern society, the moral harm caused to the patient in the course of psychotherapeutic work, the harm that accompanies the use of invasive research methods and the method treatment with side effects);

- conducting research on patients with mental disorders, as well as using information about patients during the training of students and doctors, in scientific publications (if patients are not recognized as incompetent and can not give informed consent.) There is no generally accepted criterion for determining the legal capacity to obtain consent for participation in the study).

4.11 Ethical problems in narcology

Since narcology is a section of psychiatry that deals with the diagnosis, treatment and prevention of diseases manifested in the addiction to the use of narcotic drugs and drugs as a result of persistent mental and physical dependence on them, then in this field the principles and norms of bioethics operate in a peculiar way:

- the principle of the autonomy of the individual (dependent patients on compulsory treatment for alcoholism or drug addiction are a non-autonomous person. In this case, the problem arises of implementing informed consent);

- The principle of non-harm (some drugs used in the narcology cause dangerous side effects in patients with complete absence or poorly proven effectiveness, but this treatment is the "lesser evil");

- the principle of beneficence (the narcologist independently chooses as the moral values the life and health of the patient, ignoring the autonomy of the individual (freedom of self-determination of the patient));

- the principle of fairness (patients with narcological pathology are not socially valuable. Professionals argue that the society's costs of treating addicts will be many times compensated through the preservation of their life and work capacity).

4.12 Conceptual model of the professional culture of the doctor at the present stage: structure, content

The end of the 20th and the beginning of the 21st century is marked by a new approach to the professional culture of the doctor, the search for more flexible and open models of her, capable of responding better to the sociocultural "challenges" of time. The innovative type of the modern professional culture of the doctor, in our opinion, can be represented in the form of a conceptual model (cultural and educational project), based on the following main components:

• *genetic predisposition to healing* (vocation): intellectual and physical abilities, makings (the ability to learn, not to be afraid of blood, etc.), the presence of appropriate moral qualities (the ability to sacrifice oneself for the sake of fulfilling a professional duty);

• *professional competence*: the availability of professional knowledge, skills, skills (the need and desire to learn for life), on the basis of which the doctor makes decisions regarding the diseases;

• *developed common culture*: the ability to rely on the general cultural potential in their activities; familiarizing colleagues and patients with culture and art; observance of an optimum mode of work and rest; the use of progressive experience in the organization of labor relations;

• *clinical thinking*: logical organization of medical activity with the purpose to find the features of the pathological process, characteristic for a particular patient; constructs the main procedural-methodological schemes of cognition, constructs hypotheses, carries out conceptual and strategic goal-setting, owns methods of reflection and self-reflection; the ability to mentally construct a synthetic picture of the disease, the reconstruction of the "internal flow" of it according to external signs;

• *the moral system* (Good, Suffering and Compassion, Duty and Conscience, Honor and Dignity, Freedom and Responsibility), *aesthetic* (sense of Beauty, Harmony, Measure, Beauty), *social, vital-biological* (Health, Life, awareness of the category Death). They determine the behavior of the doctor in the medical environment and in public life, form the ethical code of the doctor;

• the presence of *high moral qualities* such as: humanity, charity, kindness, compassion, responsibility, passion for one's profession, dedication, professional duty (to the patient and his relatives, colleagues and society), ability to console, decency, honesty, conscientiousness, self-control, diligence, increased self-sensitivity, responsiveness, high tolerance, patience, courtesy, gentleness of attentiveness, attentiveness, empathy, aspiration for self-improvement, listening skills, law obedience, independence and self-confidence, dignity, integrity, collegiality, partnership, benevolence, lack of

selfishness, authority among patients and colleagues; strong-willed qualities: owning oneself in stressful situations, thoughtfulness and resoluteness of actions, perseverance in achieving the goals of medical activity, optimism, commitment, compulsion, pedantry, intolerance to negligence and bad faith of colleagues;

• *Ethical and bioethical culture, observance of professional traditions* (doctor's vows, deontological codes, medical symbols): the doctor is obliged to know about ethical and bioethical problems of medicine, the ability to be guided by this knowledge in his professional activities, to observe professional traditions. The basic principles of biomedical ethics should be based on the new model of relations in the "doctor-patient" system: do no harm, benefit, autonomy of the person, informed consent, confidentiality, voluntariness, integrity, vulnerability, truthfulness, privacy, respect for a person as a person, charity principle and mercy, justice, solidarity, etc. In the "doctor-patient" system, the priority of the autonomous model of relationships and the observance of the principle of informed consent. The doctor, implementing the principle of "informed consent" in the system of relationships, must solve three problems. The first is the preparation and submission of information that should help the patient make the right decision and at the same time be free from elements of coercion and manipulation. The second is recognition of the patient's autonomous decision. The third is the conscientious implementation of the treatment chosen by the patient;

• *psychological culture*: allows you to manage your current mental state; knowledge of the patient's mental characteristics (the symbolic values of verbal and non-verbal behaviors of the patient: voice timbre, intonation, speech speed, pauses between words, silence, appearance, expression of the eyes, gestures, facial expressions, postures and other signs) will allow the doctor to build more adequately its psychotherapeutic tactics and mobilize the person's mental reserves to overcome the ailment; provides a favorable socio-psychological climate with patients and colleagues (setting for an emotionally positive attitude and anthropocentric approach to the patient, regardless of his personal qualities);

• *communicative culture*: the ability to communicate effectively and establish business contacts, both with patients, their relatives and friends, and with medical personnel; mastery of the culture of speech. The doctor should be peculiar to the business level of communication (takes into account the personality, character, age, mood of the interlocutor in the focus on the interests of the case), but must be equal and coordinated with the interests of the patient on the basis of theoretical knowledge. For him, emotional restraint, efficiency, a narrow focus on the common cause, judiciousness, politeness, emotional involvement should be inherent. Indicators of the speech culture of the doctor are: fluency in the literary language, the ability to

correctly build their thoughts and correctly describe them. Speech should be specific and concise: in conversation with patients it is necessary to speak in simple language, kindly, to choose exact words, to avoid scientific expressions loaded with incomprehensible words that can strengthen the patient in the belief that he suffers from severe organic diseases; do not use word-parasites. Pronunciation is clear, correct accent. Moderate intonation and loudness. The doctor should have an optimal speech speed (not fast and not slow). For a better perception of the information, the interviewees should have close indicators of the speed of speech and thinking. An unintentionally loud or quiet voice of a doctor can irritate both patients and colleagues. Do not abuse gesticulation. Success in communication and business interaction depends on: the ability to collect information, asking questions in order to get the most complete and accurate information; from self-reliance and professional competence; from the ability to interact with colleagues and patients, developing a common position in matters of strategy and tactics of cooperation;

• *legal culture*: regulates medical activity in accordance with the current legislation, orders of the administration;

• *religious competence* of the doctor: awareness of medical intervention to believing patients, respect for their right to choose religious faith; allows the doctor to make the right choice in the treatment process based on the characteristics of the patient's religious faith;

• *research culture*: introduction of innovations into practice; develop his creative potential; develop clinical thinking, improve cultural and intellectual level;

• *organizational culture*: the ability to carefully plan your work day, the opportunity to work in a team, and if necessary skillfully coordinate the activities of your colleagues, patients, make optimal decisions in standard and unusual situations. Indicator is the availability of leadership qualities, organizational skills; preservation of power positions within the framework of official status without coercion, enjoys authority among employees, carries out latent leadership;

• *information culture*: possession of both technical means (the ability to work with medical equipment), and computer literacy, the ability to use the Internet); ability to informational and analytical support of decisions in the treatment process;

• *culture of a healthy lifestyle*: motivation to lead and promote a healthy lifestyle; convince employees and colleagues to be guided by rational methods and humanistic values in their lives;

• *ability to pedagogical activity*: the ability to understand, understand, and methodically correctly explain to students and colleagues the medical questions they are interested in (transfer professional experience);

• *neat appearance and disposable property*-spatial environment (aesthetic culture): ability to create the necessary external image and having a spatially-material working environment (beautifully decorated interior, neat workplace). The appearance of the doctor should create the impression of a respectable, intelligent and prosperous person, inspiring respect, trust and respect. The face of the doctor must always be expressive, informative. Eyes - intelligent, energetic, spiritual and inquisitive, cheerful, if necessary compassionate. The skin of the hands is clean, the nails are short-cropped. Gestures, postures, posture of a doctor are ethical, aesthetic. In terms of jewelry, there should be a sense of proportion. Clothes - practical, hygienic and aesthetic. The white doctor's gown should be spacious and comfortable, clean and ironed, without ornaments. On the head of the doctor should be a cap.

• in connection with the expansion of the spectrum of paid services in the current socio-cultural environment and the limited availability of medical resources, the need for an *economic culture* (in no way prevailing over the moral traditions of healing) increases, allowing the most rational activity, using available resources.

References:

1. Beauchamp, T. Principles of Biomedical Ethics / T. Beauchamp, O. Childress.– N.Y., Oxford, 1989. – p. 90.
2. Vich, R. Models of moral medicine in the era of revolutionary change / R. Vich // Questions of Philosophy. – 1994. – №3. – p. 66–72.
3. Siluyanova, I. Moral culture of the doctor as the basis of medical professionalism / I. Siluyanova // Health Economics. – 2000. – №1/42. – p. 5–8.
4. Basic ethical principles in European bioethics and biolaw. Jacob Dahl Reindtorff and Peter Kemp (Editors). Vol. I. Autonomy, dignity, integrity and vulnerability, 428 p. Vol. II. Partners' research, 372 p. Institut Borja de Bioetica, Barcelona, Spain, 2000. Review B. Yudin // Questions of Philosophy. – 2003. – №5. – p.181.
5. Mishatkina, T. Principle of confidentiality and non-disclosure of medical secrets / T.B. Mishatkina, E. Phonotova // Medicine. – 2008. – №3. – p. 6-9.
6. Mishatkina, T. Universal principles, moral norms and values of biomedical ethics / T. Mishatkina // Bioethics and humanitarian expertise: problems of genomics, psychology and virtualistics / RAS, IF;editor F. Mailenova – M., IF RAS, 2008. – p. 27–47.

Topics of reports, abstracts and creative projects

1. Appearance of a medical professional.

2. The main elements of the doctor's business etiquette.

5. Awareness of medical workers on ethical and legal issues in medicine.

6. Attitude to the principle of informed consent in modern medicine.

7. Ethical features of the doctor's behavior at the survey stage.

8. Ethical rules of instrumental survey.

9. Modern ideas about self-treatment.

10. The word as a therapeutic factor.

11. Peculiarities of professional communication with the patient, depending on his age, character formation, stage and severity of the disease.

12. "Unpleasant" patient and peculiarities of professional behavior with him. Peculiarities of professional behavior in the case of treatment of VIP-patients.

13. Peculiarities of professional behavior with an oncological patient.

14. Peculiarities of professional behavior with a psychiatric patient.

15. Peculiarities of professional behavior with a therapeutic patient.

16. Peculiarities of professional behavior with a surgical patient.

17. Peculiarities of family patronage in relation to newborns, mentally ill, disabled, elderly patients.

18. The problem of error and iatrogeny from the medical and ethical positions. The importance of consultations, clinical conferences in the prevention of errors. Self-control and mutual control.

19. The responsibility of the doctor for the mistakes made. Errors in the preparation of documentation. Insurance against errors. Error and criminal intent.

20. Mutual relations in the medical team. Moral climate in the team.

21. Principles of veracity, informed consent, confidentiality. Information relating to medical secrecy.

22. Ethical requirements for medical workers in respect of medical secrecy.

23. Conditions for disclosure of medical secrets. Temporary boundaries of medical secrecy. Ethical rules for publishing patient information.

27. Doctor and society in the era of development of new biomedical technologies.

28. AIDS and the professional risk of health workers.

29. Problems of socialization of HIV-infected children.

30. Rehabilitation of drug addicts and HIV-infected people.

II. COMMUNICATIONS IN HEALTH SERVICE

1. COMMUNICATIONS IN THE ACTIVITIES OF MEDICAL WORKERS

1.1. Definition of the concept of "communication".

1.2. Basic principles and goals of communication in health.

1.3. Scheme of communications. Communication process.

1.4. Postures, facial expressions, gestures.

1.5. Tactical means of communication. The art of hidden influence.

1.6. Types of communication of medical workers. Formal communications, informal communications. Types of informal communications.

1.1. Definition of the concept of "communication"

The term "communication" appeared in the scientific literature at the beginning of the 20th century. It is used in the following values.

1. Communication (from the Latin "communication - transmission and from "communicare"- to make common, to talk) as a necessary element of interaction of people, groups, nations, states, during which information, feelings, assessments are transmitted.

2. Communication is a process of bilateral exchange of information leading to mutual understanding.

Communion is a socially conditioned process of the exchange of thoughts and feelings between people in various spheres of their cognitive-labor and creative activity, realized mainly through verbal means of communication. In contrast, communication is a socially conditioned process of transmitting and perceiving information both in interpersonal and in mass communion through different channels by using various verbal and non-verbal communication tools. The problem not so much the exchange of information, as its adequate understanding arises in the process of communion.

There are a large number of definitions of communication. Thus, in the dictionary "Contemporary Western Sociology" the following interpretation of the concept of communication is given:

1) means of connection of any objects of the material and spiritual world;

2) the communion, the transmission of information from person to person;

3) communion and exchange of information in society, i.e. social communication.

According to the encyclopedic sociological dictionary, communication is the transfer of information from one system to another, through special material carriers, signals.

In the "Modern Dictionary of Foreign Words" this concept is defined as:

− the way of communication (air, water, etc. communication);

− the form of connection (telegraph, radio, telephone);

− the act of communion, a connection between two or more individuals, the basis for mutual understanding;

− the process of communicating information using technical means - media (print, radio, cinema, television).

Thus, communication is:

a) means of connection of any objects of the material and spiritual world;

b) process of communion, transfer of information from person to person;

c) transfer and exchange of information in society to influence it.

In human society, communication is realized between individuals, groups, organizations, states, cultures through sign systems (languages). Communication between people occurs in the form of **communion** as an exchange of integral sign messages, in which knowledge, thoughts, ideas, value relationships, emotional states, programs of activities of communicating parties are displayed. The content and forms of communication reflect the social relations and historical experience of people. Communication is a necessary prerequisite for the functioning and development of all social systems. It provides connection between people, allows to accumulate and to transfer social experience, provides division of labor and organization of joint activities, management, broadcasting of culture. The need for communication consists in the striving of man to the knowledge and evaluation of other people, and through them – to the self-knowledge and self-esteem. Communication permeates all aspects of society, social groups and individuals.

It is proved that poor communication skills on the part of the doctor are the main factor leading to dissatisfaction of the patient and his relatives with the treatment. Patients are always less satisfied with doctors when the latter say more in an interview than a patient, or when the emotional background is characterized by their dominance. The patient's expectations about the role of the doctor have changed. People want to see themselves as more active participants in caring for their own health.

1.2. Basic principles and goals of communication in health

Qualification is only a tool, the effect of which depends on the other aspects of the physician's personality, in particular his ***communicative competence***.

The term "communication" has three interpretations: a) media; b) transfer of information; c) the impact of information.

Basic principles of communication:

- it has a purpose;
- it is continuous, relative - the person always sends behavioral messages, from which the interlocutor derives meaning or draws conclusions;
- it has sociocultural boundaries - the formation of the message and its interpretation depend on the socio-cultural affiliation of the participants: ethnic, racial, religious, sex and age affiliation, sexual orientation, social status, education;
- it has an ethical aspect.

A goal is something to aspire to, something to be done. Any communication is purposeful! The main goals of communication typically include:

- exchange and transfer of information;
- the formation of skills for successful socio-cultural activities;
- the formation of the attitude to yourself, to others, to society as a whole;
- exchange of activity, innovative receptions, means, technologies;
- change of motivation of behavior;
- the exchange of emotions.

<u>Communication in the health sector is designed for:</u>

- informing the public about health issues;
- training in practical skills for healthy lifestyles;
- strategic planning in the field of health;
- implementation of social partnership - organization of interactions with stakeholders;
- formation and maintenance of motivation of subjects in the process of communication on health issues.

Communication in healthcare involves not only informing the subjects on various health issues, but also the transformation of this information, building up strategies for interaction with the public, the media and the network of partners.

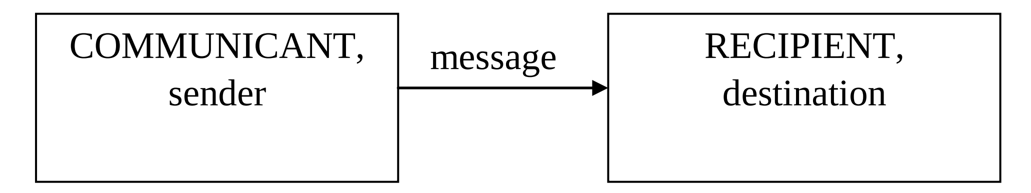
Planning communication, you must first determine the target audience and only then choose the ways and channels of information transfer. It should be borne in mind that with the help of traditional communication channels - and especially through the Internet - it is difficult to convey information to all target groups.

Communication is a long-term activity, because behavioral attitudes of people, their attachments and habits change slowly enough. It is necessary to be able to distribute information purposefully. Communication should not be one-sided - it is a complex process, including the possibility of a response to information from all actors. Highlighting health topics, trying to influence behavioral attitudes of communication subjects, it is necessary to take into account all possible difficulties that arise in the transmission of information.

It is very important to organize permanent, long-term work of reliable sources and channels of information to ensure the quality of the offering and receiving information, as well as the formation of a universal, non-nominal value of health.

The main and only subject of communication is a person who, in order to ensure his life, enters into a relationship with other people. Man, people, groups of people, organizations, society are the subjects of communication who have the right to receive information on health issues. The subjects of communication should also carry out internal interaction on information support issues.

1.3. Scheme of communications. Communication process



The elementary scheme of communication shows that communication assumes the presence of at least three participants: the transmitting entity (communicant) - the transmitted object (message) - the receiving entity (recipient). Therefore, communication is a kind of interaction between subjects, mediated by some object. To distinguish communication from other processes, let's pay attention to its following ***distinctive features:***

1. As participants in communication, there are two subjects that can be: an individual or a group of people, up to the society as a whole, as well as animals (zoocommunication). According to this feature, the interaction of inanimate objects is excluded from the concept of communication, i.e. the relationship, for example, of the Sun and the Earth is not a communication process.

2. The presence of the object being transferred is necessary. It can have a material form (a book, speech, gesture, gift, etc.) or not have it. For example, a communicant can unknowingly influence the recipient, inspiring him with confidence, sympathy, antipathy, love. A degenerate form of communication is a person's communication with himself (inner speech, reflections, memories, etc.).

3. Communications are characterized by expediency, or functionality, so nonsense is not a communicative act.

It is possible to give the following scientific interpretation: communication is an indirect and expedient interaction of two subjects.

A communication process is a process of sharing information between two or more people.

The communication process is a sequence of interrelated steps necessary for the implementation of information exchange: the formulation of an idea, the coding of information, the choice of a communication channel and the transmission of a message, the decoding of a message, the formulation of a response, and its transmission to the sender.

The purpose of the communication process is to provide an understanding of information that can be called a message. Knowing the role and content of each stage allows you to more effectively manage the process as a whole. Let's consider separate components and stages of the given process:

1. The origin of the idea.
2. Coding and channel selection.
3. Transfer.
4. Decoding.

(See the chapter "Organization of the communication process in health service" below).

1.4. Postures, facial expressions, gestures

Speech activity is accompanied by facial expressions, gestures, poses. They carry an informational load reflecting the physical and emotional state of the speaker, his temperament, personality traits and qualities, and also give information about the nature of the relationship, the situation of communication, the level of understanding, etc. (Kinesika - the science of gestures and facial expressions).

In his book The Language of Body Movements, the Austrian writer Alan Pease argues that each person perceives information on the basis of this calculation: 7% of information comes with words, and the remaining 93% are perceived by us with non-verbal signals (sounds and intonations 38%, non-verbal Interaction 55%).

Knowing the types of non-verbal communication and understanding nonverbal signals is important for several reasons. First, they perform the functions of expressing feelings, because very often we experience feelings so complex that we simply cannot find the right words for their description, but this can be done using nonverbal tools and methods. Secondly, they serve as a deeper understanding. Nonverbal signals are manifested unconsciously, and the interlocutor simply cannot control them. Nonverbal means of communication and examples of their use help to better understand oneself, they also learn to recognize lies and manipulations from other people. You should learn to pay attention to all elements or means of non-verbal communication. Nonverbal means of communication include facial expressions, gestures, postures, intonation and timbre of voice, visual contact and interpersonal space.

Mimicry is an expressive stereotyped reaction of the musculature of a person's face. It is the main element of the display of emotions and feelings. Emotions are differently reflected on the right and left side of the face, because the left and right hemispheres of the brain perform different functions: the right hemisphere controls the emotional sphere, and the left one is responsible for the intellectual functions. Emotions are expressed in facial expressions in this way:

− anger - wide open eyes, lowered corners of the lips, "narrowed" eyes, clenched teeth;

− surprise - a slightly open mouth, wide open eyes and raised eyebrows, lowered lips tips;

− fear - folded eyebrows, stretched lips with lowered and lowered corners;

− happiness - a calm look, raised, backward corners of the lips;

− sadness - "extinct" look, lowered corners of the lips, bent eyebrows.

− Pleasant general themes support eye contact, and negative intricate questions make you look away, showing disagreement and dislike. The features of visual contact allow you to draw conclusions about the degree of interest in the dialogue and attitude to the interlocutor:

− admiration - long eye contact, calm look;

− indignation - a close, obsessive, somewhat anxious look, prolonged eye contact without pauses;

− location - close look, eye contact with pauses every 10 seconds;

− dislike - avoidance of eye contact, "rolling" of the eyes.

− waiting - a sharp look in the eyes, raised eyebrows.

Intonation and timbre of voice. The features include frequent pauses, unfinished sentences and their construction, the strength and height of the voice, as well as the speed of speech:

− excitement - low tone of voice, fast, steep speech;

− enthusiasm - high tone of voice, clear confident speech;

− fatigue - low tone of voice, lowering intonation towards the end of the sentence;

− arrogance - slow speech, even monotonous intonation;

− uncertainty - errors in words, frequent pauses, nervous cough.

Gestures along with facial expressions are the most important elements of human communication. Long before mastering a coherent speech, a person used various movements of the body to convey information and his attitude to what is happening. Feelings and attitudes of people are determined by the manner of sitting, standing, by the set of gestures and individual movements. People are easier and more pleasant to communicate with those who have expressive motor skills, animated relaxed facial expression. Bright gestures reflect positive emotions and have to sincerity

and trust. In this case, excessive gesticulation, often repeated gestures can talk about inner tension and self-doubt. Nonverbal communication becomes available, and the level of mutual understanding increases, if the postures and gestures of the interlocutor will be understood.

Alan Pease is of the opinion that the gestural communication is universal, along with mimic communication. Nodding in the greater part of the world's population is a sign of agreement or approval. Together with this, the movement of the head from side to side acquired and firmly consolidated the value of disagreement:

− concentration - closed eyes, tingling of the bridge of the nose, rubbing the chin;

− criticality - one hand near the chin with an extended index finger along the cheek, the second hand supports the elbow;

− positivity - the body, the head slightly tilted forward, the hand slightly touches the cheek;

− distrust - the palm covers the mouth, expressing disagreement;

− boredom - the head is backed by the hand, the body is relaxed and slightly bent;

− superiority – sitting position, feet one on top of another, hands behind head, eyelids are slightly covered;

− disapproval - uneasy movement, shaking "villi", dressing, pulling up trousers or skirt;

− uncertainty - scratching or rubbing the ears, grasping the elbow of the other hand with one hand;

− openness - hands are spread out with the palms facing upwards, shoulders are straightened, the head "looks" straight, the body is relaxed.

Gestures are viewed as external manifestations of the inner emotional state of a person, while they contain information not only about the psychological state of individuals, but also about the intensity of the experience. The decisive factor and condition for the production and understanding of the gesture is rightly considered the context.

Pose. Important in assessing the status of the interlocutor, the partner for interaction, has a pose - how he stands, sits. Positions are divided into natural and unnatural. The natural pose - free, relaxed - characterizes psychological comfort, lack of tension and disposes to communication. Pose unnatural - unusual, strange, ridiculous - does not have communication, it indicates tension, psychological discomfort. Positions can be symmetrical and asymmetric. A symmetrical pose balances individual differences, just like uniforms, making people somewhat similar to each other. Symmetrical posture - an element of formal communication, suggests formal, regulated interaction. It is preferred by people who are closed-minded, secretive, restrained, prudent in their relationships, distrustfulness, suspiciousness, which does not imply proximity and cooperation, and therefore they do not

cause trust. Pose asymmetric, on the contrary, indicates individual characteristics, openness to communication, willingness to cooperate. Poses are also closed and open. Closed posture indicates an unwillingness to communicate, avoidance of relationships with others. The distinctive features of the closed posture include such characteristics as crossed arms ("Napoleon's pose"), crossed legs (leg to foot); hands are in pockets, hidden behind the back; body and head are deployed away from the partner; look is directed at the floor, the window, the medical history - anywhere, but not into the eyes of the interlocutor.

The doctor in the situation of his professional communication with patients is best to use natural, asymmetrical, open poses, which have to communicate, do not cause tension or mistrust, creating better conditions for interaction. This is especially important at the very beginning of communication, when establishing psychological contact with the patient.

Interpersonal space. The distance between the interlocutors plays an important role in establishing contacts, understanding of the situation of communication. People often express their attitude in such categories as "stay away from there," or "I want to be closer to him." If people are interested in each other, sharing their space decreases, they tend to be closer. For a better understanding of these features, as well as to correctly distinguish between the situation and the scope of the contact, you should know the basic limits of the allowable distance between the interlocutors:

− intimate distance (0.5m) - the intimate relationship of trust between relatives and friends,

− interpersonal distance (from 0.5m - 1.2m) - a comfortable distance during a friendly conversation, which allowed touching each other,

− social distance (from 1.2m - up to 3.7m) - informal interaction in society, during a business meeting. The greater the distance, until at the border, the relationship formal,

− public distance (over 3.7m) – a comfortable distance for the lecturer, who makes a public appearance before a large group of people.

Such a framework of distances and their value depends on the age, sex of the individual, his personal characteristics. Children comfortable is at a close distance from the source, and teenagers are closed, unwilling to move away from the others. Women love a closer distance, regardless of gender of the interlocutor. Balanced, self-confident people do not pay much attention to the distance, while the nervous anxious people are trying to stay away from others.

An important role in the communication process plays such a thing as a congruence (correspondence) body language uttered speech, i.e., non-verbal and verbal components of communication. Non-verbal signals, concluding a five times more information compared to verbal incongruence in the case are the most reliable source of information about the true state of affairs.

Thus, the body language is a very important phenomenon in human communication. It reflects the feelings, the emotional and physical state of a person, allowing the other party to respond to them correctly. Facial expressions, postures and gestures are not only significant human communicative signals, but can be crucial in social interaction.

1.5. Tactical means of communication. The art of covert influence

Tactics (gr. – "art of the command of the army") communication is a system of sequence actions that contributes to the realization of the selected strategy to achieve the goal.

Tactics is the implementation in a concrete situation of communicative strategies (open − closed communication; monologic – dialogic; role (the social role) − personal (communication "heart to heart")) on the basis of knowledge of the rules and mastery of the technique of communication. This is the set of specific communicative skills of speaking and listening skills.

In communication there are also the following positions:

- friendly (making the interlocutor);
- neutral;
- hostile (the rejection of the interlocutor);
- dominance, or "communication on top";
- the communication "equal";
- the subordinate, or inferior position.

Tactical communication is a dynamic touch in the form of a handshake, a pat, a kiss. A whole age group (e.g. young children), social groups (doctors, cosmetologists, masseurs, bath attendants) are touched. In Russian culture, touch is always the invasion of privacy of another, so they must be unobtrusive. There are the important functions of touch in the act of communication:

- expression of participation, concern or friendship towards the recipient of the gesture;
- the expression intimate relationship to the recipient;
- making contact or attracting attention;
- a reflection of the dominant status of the speaker on the social ladder.

In speech among tactile verbs (verbs of feeling) such verbs as stoke, touch, hug, slap, pat on the cheek, etc. are consumed.

Impact − targeted transfer of movement and information from one party to another. Stand out:

- immediate impact − contact, when the motion and concluded the information it transmitted to the pulse shape of motion - such as touch or stroke;

- indirect effects − distant, when the information coded in it the momentum is transferred in the form of complex signals, carrying a message about something, and orienting the godfather of the impact relative to the meaning and significance of these signals.

Hidden impact − the impact occurring in a stealthy manner. Hidden effects can be a natural process, and can be organized by someone against someone. Examples of hidden impact: manipulation and training.

The impact is hidden by adding the following factors:

1. The surprise or uncertainty of the situation.
2. Unclear motives.
3. Disguise.
4. Appeal to the subconscious.
5. Maneuvers: instead of a direct attack or line protection − a clever and unexpected moves, distraction, and other effects on the partner, changing the nature of the situation and frequently resolves the conflict itself.

The psychology of managing people is a full-fledged branch of science that studies the types and methods of psychological influence of the person, methods of direct and covert control of society and individuals. Mastering the psychology of managing people, the doctor should be able with the help of psychological methods to persuade patients to certain actions that contribute to their speedy recovery, volunteer to make the patient's functioning in the interests of their health.

Recommended:

1. To work on expressive and understandable non-verbal.
2. To establish and maintain constructive communication more often openly to indicate intentions.

1.6. Types of communication of medical workers. Formal communications, informal communications. Types of informal communications.

The following types of communication: interpersonal (spontaneous, formal or informal communication between employees of the organization) and organizational (integrated and complex system of transmission and exchange of information within the organization).

Communication is a tool using which, you can send a message from source to destination. The recipient may be more than one person. So, during the presentation, the lecturer transmits information to the whole audience. The message may not be limited to text or sound. Often it includes intonation, gestures, etc.

Non-verbal and **verbal** channels are historically the first of the channels of social communication.

In modern society the transmission of information is carried out on the basis of the used channels and means of material and technical

equipment. In this regard, there are the following types of social communication:

- oral. This communication uses both natural nonverbal and verbal channels, as well as funds,
- documentary. This communication applies to information transmission channels that have been artificially created by man. These include printing, writing and visual art that convey meaning in space and in time,
- electronic. It is based on wired and wireless, computer equipment, magnetic and optical recording devices.

All three kinds of social ways of communication exist in unity with each other.

There are two types of scientific communication: informally − through direct contact between the sending and receiving information by specialists or formal − using different types of scientific medical literature and secondary information sources.

Formal communication is communication that link the individual elements of organizational structure are derived from the goals of the organization and establishes by rules enshrined in job descriptions and internal regulations, which reglamentary the interaction of workers or units.

Informal communication in General is not associated with the hierarchy of the organization, they connect people, which are combined within a single informal group. They arise in any organization, but usually are not related to its direct needs, are carried out according to the established system of personal relationships between employees of the organization.

Communication tools are differed in their nature to the signs of verbal – words, phrases, which form a verbal system; non-verbal – gestures, facial expressions, posture, gestures, the features of voice (pitch, volume, tone), characters (alphabetic, numeric, graphic, color) that make up the nonverbal system; synthetic images (scenic, cinematic, visual, musical, literary), which combine verbal and non-verbal signs to form a synthetic system in certain types of art.

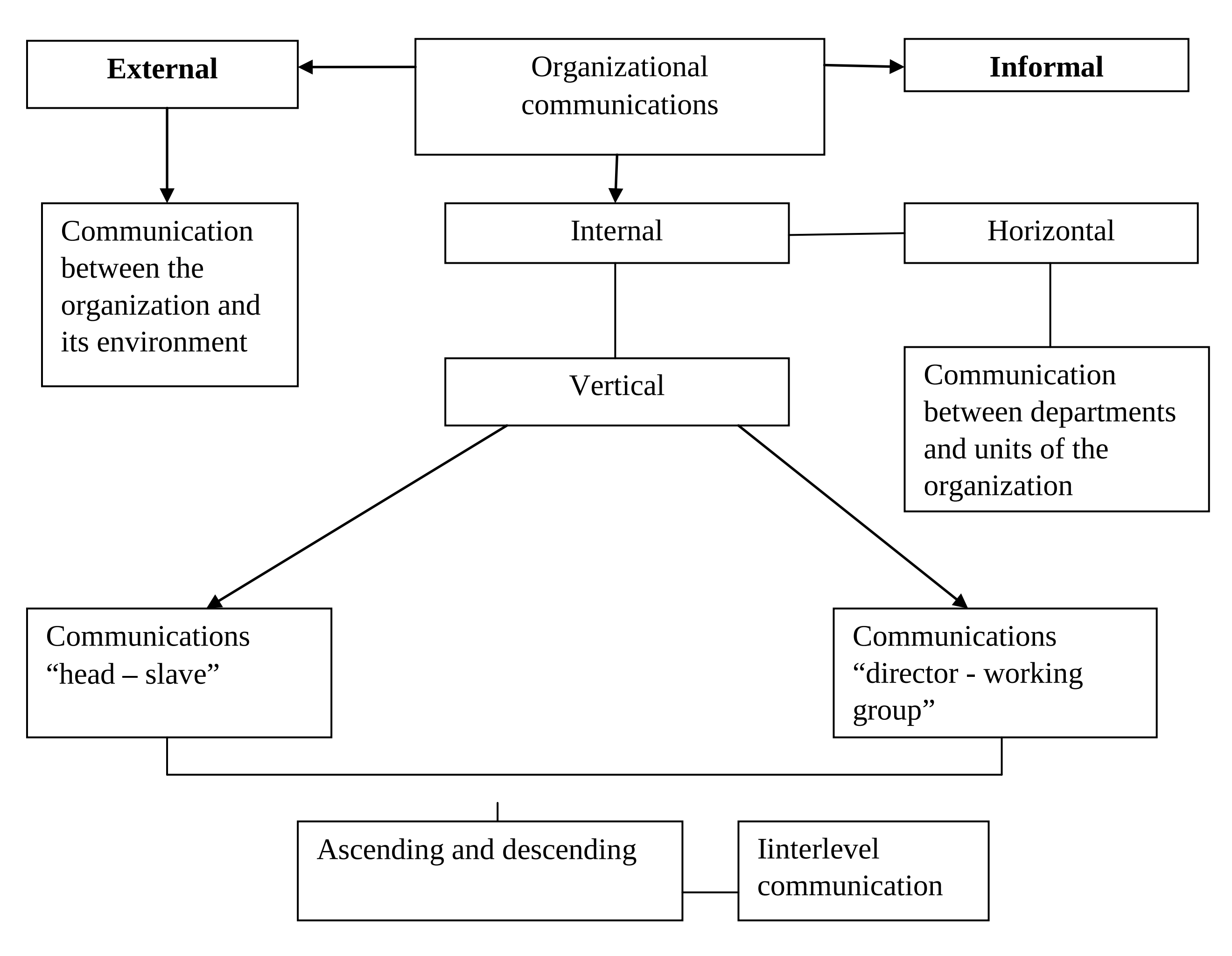
Verbal communication includes oral and written.

Oral are direct (dialogue, presentation, meeting, negotiation) and indirect (voice communication, a telephone conversation).

Writing tools: letter, memorandum, report.

In describing the types of non-verbal communication the body language (posture, gesture, facial expression), and the parameters of speech (intonation, voice volume) are isolated. Non-verbal means of communication are divided into basic: visual, skin reactions, reflecting the distance, acoustic or sound, extralinguistic, tactile-kinesthetic, olfactory (smell), auxiliary means of communication, including the different physical characteristics (sex, age), and their conversion tools.

The structure of organizational communication is presented in the scheme



With existing and potential customers the organizations communicate through advertising or other promotion programs of products on the market, among which the most effective are conferences and business meetings, fairs, trade shows etc. In the field of public relations focuses on the creation of a specific image, the "image" of the organization at the local, national or international level. In this widely used radio, television, the allocation of funds to charitable and other funds, financing, environmental, health and other programs.

In the health service system communications with the external environment include obtaining and compliance with orders of the Ministry of health, orders and guidance etc. the subject of the communications is information about the achievements of medical and pharmaceutical science and practice, the production and registration of drugs, on the status and trends of the pharmaceutical market, as well as accounting and statistical reporting.

Internal communications are a complex and all-pervasive process that encompasses all levels and sub-levels of the organization.

The hierarchical structure of the organization leads to the movement of information from level to level within the framework of inter-level vertical communications. Vertical communications can be carried out both downward - from the highest managerial levels to the lower levels, and from the bottom up - from the grassroots to the higher levels. Through communications on the downstream subordinate levels of management, current and specific tasks, forthcoming changes in production, etc. are reported.

An example of the exchange of information on the vertical can serve as communication between the leader and the subordinate. The essence of these communications is quite diverse: clarifying tasks, discussing performance problems, collecting information, notifying subordinates about something, getting information about improvements and suggestions, gratitude and rewards. Communication with the working group as a whole allows the leader to improve the effectiveness of the group. Since all the members of the group participate in the exchange, everyone has the opportunity to express their opinion, which ultimately leads to an optimal solution.

Due to the variety of tasks facing the organization, it needs not only vertical, but also horizontal communications. The organization consists of a number of units, so the exchange of information between them is necessary to coordinate their actions (information exchange, increasing the effectiveness of activities, the formation of equal relations between employees of different departments, maintaining a normal psychological climate in them and the organization as a whole).

One of the most significant characteristics of an organization is its relationship with the external environment. Organizations use a variety of means to communicate with the components of their external environment. So, they have to obey state regulation, on the other hand, the organization tries to influence the content of future laws and regulations.

In addition, communication tools differ in the degree of generalization of the transmitted information (semantic, evaluation). This is an integral characteristic that influences their choice in a specific communicative situation.

According to the subjects of communication and the type of relations between them, it is customary to distinguish the following types:

1. Interpersonal communication is a kind of person-oriented communication, connected with the exchange of messages and their interpretation by two or more individuals who have entered into certain relations among themselves; The type of communication in a situation of interpersonal interactions and / or relationships.

2. Intergroup communication is a kind of interaction of people determined by their belonging to different social groups and population

categories, independent of their interpersonal connections and individual preferences.

3. Public communication is a kind of institutional (status-oriented) communication with the public (a significant number of listeners); Communication in such communication affects the public interest and acquires a public character.

4. Mass communication is a process of systematic dissemination of information, which is of an institutional nature, as well as the transmission of specially prepared messages using various technical means to numerically large, anonymous, dispersed audiences; Is a regulator of the dynamic processes of public consciousness, an integrator of mass sentiments, as well as a powerful means of influencing individuality and group.

Thus, there are the following types of communications: interpersonal, group, mass communication. They can be carried out in various spheres (cultural and spiritual, scientific, educational, production), among people of different ages, sex belonging to different peoples, nations, ethnic groups, races (gerontocommunications, gender, ethnic-ethnic, interracial communication), between different Categories of the population (youth, women, religious), between continents, countries, states, peoples, territories (intercontinental, interstate, international, interterritorial), etc.

Types of communication are distinguished by the composition of communicants: (interpersonal, group and mass communication).

Types of communication: the way to establish and maintain contact communication are divided into direct (direct), mediated (remote); On the initiative of communication communicators are divided into active and passive; On the degree of organization of communication are divided into random and organized; Depending on the sign systems used, communication is divided into verbal and non-verbal.

Forms of communication. The forms of communication include discussions, talks, meetings, meetings, negotiations, briefings, press conferences, presentations, personal matters, telephone conversations, business correspondence, etc.

Areas of communication. Communication spheres are united by the concept of specialized communication. Traditionally distinguished are: the sphere of everyday, political, scientific, educational, pedagogical, legal, medical, religious, industrial communication.

Informal communications. The channel of informal communications can be called a channel for spreading rumors. Informal channels often act faster than formal ones, and almost always the trust of communicants to informal information is higher than to a formal source.

Topics of reports, abstracts and creative projects

1. Communication theories.

2. Leader's qualities of a doctor.
3. Psychological types of effective leaders.
4. Ethics of the business relationship of a medical worker.
5. The collective. Time management.
6. The word doctor as a therapeutic factor.

2. LEADERSHIP AND AUTHORITY

2.1. Leader and leadership: terms and conception.
2.2. Categories and types of leadership.
2.3. Scope of leadership: formal and informal.
2.4. Leadership Qualities.
2.5. Criteria of leadership.

2.1 Leader and leadership: terms and conception

The word leadership can refer to:

• The traits, behavior, influence, interaction patterns, role relationships and occupation of an administrative position.

• Articulating visions (e.g. Bill Gates), embodying values and creating environment for the things that can be accomplished.

• Those entities that perform one or more acts of leading.

• The ability to affect human behavior so as to accomplish a mission.

• Influencing a group of people to move towards its goal setting or goal achievement.

2.2 Categories and types of leadership

Leadership has a formal aspect (as in most political or business leadership, individual persons holding the title "manager") or an informal one (as in most friendships or team activities). Speaking of "leadership" (the abstract term) rather than of "leading" (the action) usually it implies that the entities doing the leading have some "leadership skills" or competencies.

Types of leadership styles (in organizations)

The bureaucratic leader is very structured and follows the procedures as they have been established. This type of leadership has no space to explore new ways to solve problems and is usually slow paced to ensure adherence to the ladders stated by the company. Leaders ensure that all the steps have been followed prior to sending it to the next level of authority. Universities, hospitals, banks and government usually require this type of leader in their organizations to ensure quality, increase security and decrease corruption. Leaders that try to speed up the process will experience frustration and anxiety.

The charismatic leader leads by infusing energy and eagerness into their team members. This type of leader has to be committed to the organization for the long run. If the success of the division or project is attributed to the leader and not the team, charismatic leaders may become a risk for the company by deciding to resign for advanced opportunities. It takes the company time and hard work to gain the employees' confidence back with other type of leadership after they have committed themselves to the magnetism of a charismatic leader.

The autocratic leader is given the power to make decisions alone, having total authority. This leadership style is good for employees that need close supervision to perform certain tasks.

The democratic leader. This style involves the leader including one or more employees in the decision making process (determining what to do and how to do it). However, the leader maintains the final decision making authority. Using this style is not a sign of weakness, rather it is a sign of strength that your employees will respect.

This is normally used when you have part of the information, and your employees have other parts. Note that a leader is not expected to know everything – this is why you employ knowledgeable and skillful employees. Using this style is of mutual benefit – it allows them to become part of the team and allows you to make better decisions.

The laissez-faire ("let do") leader. In this style, the leader allows the employees to make the decisions. However, the leader is still responsible for the decisions that are made. This is used when employees are able to analyze the situation and determine what needs to be done and how to do it. You cannot do everything! You must set priorities and delegate certain tasks. This is not a style to use so that you can blame others when things go wrong, rather this is a style to be used when you fully trust and confidence in the people below you. Do not be afraid to use it, however, use it wisely!

The people-oriented leader is the one who, in order to comply with effectiveness and efficiency, supports, trains and develops his personnel, increasing job satisfaction and genuine interest to do a good job.

The task-oriented leader focuses on the job, and concentrates on the specific tasks assigned to each employee to reach goal accomplishment. This leadership style suffers the same motivation issues as autocratic leadership, showing no involvement in the team’s needs. It requires close supervision and control to achieve expected results. Another name for this is dealmaker and is linked to a first phase in managing Change, enhance, according to the Organize with Chaos approach.

The servant leader facilitates goal accomplishment by giving its team members what they need in order to be productive. This leader is an instrument employees use to reach the goal rather than a commanding voice that moves to change. This leadership style, in a manner similar to

democratic leadership, tends to achieve the results in a slower time frame than other styles, although employee engagement is higher.

The transaction leader is given power to perform certain tasks and reward or punish for the team's performance. It gives the opportunity to the manager to lead the group and the group agrees to follow his lead to accomplish a predetermined goal in exchange for something else. Power is given to the leader to evaluate, correct and train subordinates when productivity is not up to the desired level and reward effectiveness when expected outcome is reached.

The transformation leader motivates its team to be effective and efficient. Communication is the base for goal achievement focusing the group on the final desired outcome or goal attainment. This leader is highly visible and uses chain of command to get the job done. Transformational leaders focus on the big picture, needing to be surrounded by people who take care of the details. The leader is always looking for ideas that move the organization to reach the company's vision.

The environment leader is the one who nurtures group or organizational environment to affect the emotional and psychological perception of an individual's place in that group or organization. An understanding and application of group psychology and dynamics is essential for this style to be effective. The leader uses organizational culture to inspire individuals and develop leaders at all levels. This leadership style relies on creating an education matrix where groups interactively learn the fundamental psychology of group dynamics and culture from each other. The leader uses this psychology, and complementary language, to influence direction through the members of the inspired group to do what is required for the benefit of all.

Leadership cycles

If a group or an organization wants or expects identifiable leadership, it will require processes for appointing/acquiring and replacing leaders.

Traditional closed groups rely on bloodlines or seniority to select leaders and/or leadership candidates: monarchies, tribal chiefdoms, oligarchies and aristocratic societies rely on (and often define their institutions by) such methods.

Competence or perceived competence provides a possible basis for selecting leadership elites from a broader pool of potential talent. Political lobbying may prove necessary in electoral systems, but immediately demonstrated skill and character may secure leadership in smaller groups such as gangs.

Many organizations and groups aim to identify, grow, foster and promote what they see as leadership potential or ability - especially among younger members of society. See for example the Scouting movement. The issues of succession planning or of legitimation become important at times

when leadership (particularly individual leadership) might or must change due to term-expiry, accident or senescence.

2.3. Scope of leadership

One can govern oneself, or one can govern the whole earth. In between, we may find leaders who operate primarily within:

- youth;
- families;
- bands;
- tribes;
- organizations;
- states and nations;
- empires.

Intertwined with such categories, and overlapping them, we find for example religious leaders potentially with their own internal hierarchies, work-place leaders=corporate officer, executives, senior management-senior/upper managers; middle management - middle managers, staff-managers, line-managers, team leader, supervisors and leaders of voluntary associations.

Some anthropological ideas envisage a widespread but by no means universal pattern of progression in the organization of society in ever-larger groups, with the needs and practices of leadership changing accordingly. Thus simple dispute resolution may become legalistic dispensation of justice before developing into proactive legislature/legislative activity. Some leadership careers parallel this sort of progression: today's school-board chairperson may become tomorrow's city councilor, and then take in say a mayor Dom before graduating to nation-wide politics.

Leadership in organizations

A leader is anyone who influences a group toward obtaining a particular result. It is not dependent on title or formal authority. An individual who is appointed to a managerial position has the right to command and enforce obedience by virtue of the authority of his position. However, he must possess adequate personal attributes to match his authority, because authority is only potentially available to him. In the absence of sufficient personal competence, a manager may be confronted by an emergent leader who can challenge his role in the organization and reduce it to that of a figurehead. However, only authority of position has the backing of formal sanctions. It follows that whoever wields personal influence and power can legitimize this only by gaining a formal position in the hierarchy, with commensurate authority. Leadership can be defined as one's ability to get others to willingly follow. Every organization needs leaders at every level.

Leadership in formal organizations

An organization that is established as an instrument or means for achieving defined objectives has been referred to as a formal organization. Its design specifies how goals are subdivided and reflected in subdivisions of the organization. Divisions, departments, sections, positions, jobs, and tasks make up this work structure. Thus, the formal organization is expected to behave impersonally in regard to relationships with clients or with its members. According to Weber's definition, entry and subsequent advancement is by merit or seniority. Each employee receives a salary and enjoys a degree of tenure that safeguards him from the arbitrary influence of superiors or of powerful clients. The higher his position in the hierarchy, the greater his presumed expertise in adjudicating problems that may arise in the course of the work carried out at lower levels of the organization. It is this bureaucratic structure that forms the basis for the appointment of heads or chiefs of administrative subdivisions in the organization and endows them with the authority attached to their position.

Leadership in informal organizations

In contrast to the appointed head or chief of an administrative unit, a leader emerges within the context of the informal organization that underlies the formal structure. The informal organization expresses the personal objectives and goals of the individual membership. Their objectives and goals may or may not coincide with those of the formal organization. The informal organization represents an extension of the social structures that generally characterize human life — the spontaneous emergence of groups and organizations as ends in themselves.

In prehistoric times, man was preoccupied with his personal security, maintenance, protection, and survival. Now man spends a major portion of his waking hours working for organizations. His need to identify with a community that provides security, protection, maintenance, and a feeling of belonging continues unchanged from prehistoric times. This need is met by the informal organization and its emergent, or unofficial, leaders.

Leaders emerge from within the structure of the informal organization. Their personal qualities, the demands of the situation, or a combination of these and other factors attract followers who accept their leadership within one or several overlay structures. Instead of the authority of position held by an appointed head or chief, the emergent leader wields influence or power. Influence is the ability of a person to gain co-operation from others by means of persuasion or control over rewards. Power is a stronger form of influence because it reflects a person's ability to enforce action through the control of a means of punishment.

Effective leadership

Leadership maintains its effectiveness sometimes by natural succession according to established rules, and sometimes by the imposition of brute force.

The simplest way to measure the effectiveness of leadership involves evaluating the size of the following that the leader can muster. Within an organizational context this means financially valuing productivity. Effective leaders generate higher productivity, lower costs, and more opportunities than ineffective leaders. Effective leaders create results, attain goal, realize vision and other objectives more quickly and at a higher level of quality than ineffective leaders.

James MacGregor Burns introduced a normative element: an effective Burnsian leader will unite followers in a shared vision that will improve an organization and society at large. Burns calls leadership that delivers "true" value, integrity, and trust transformational leadership. He distinguishes such leadership from "mere" transactional leadership that builds power by doing whatever will get more followers.

But problems arise in quantifying the transformational quality of leadership – evaluation of that quality seems more difficult to quantify than merely counting the followers that the straw man of transactional leadership James MacGregor Burns has set as a primary standard for effectiveness. Thus transformational leadership requires an evaluation of quality, independent of the market demand that exhibits in the number of followers.

The functional leadership model conceives leadership as a set of behaviors that helps a group perform a task, reach their goal, or perform their function. In this model, effective leaders encourage functional behaviors and discourage dysfunctional ones.

In the path-goal model of leadership, developed jointly by Martin Evans and Robert House and based on the "Expectancy Theory of Motivation", a leader has the function of clearing the path toward the goal(s) of the group, by meeting the needs of subordinates.

Some commentators use the metaphor of an orchestral conductor to describe the quality of the leadership process. An effective leader resembles an orchestra conductor in some ways. He/she has to somehow get a group of potentially diverse and talented people – many of whom have strong personalities – to work together toward a common output. Will the conductor harness and blend all the gifts his or her players possess? Will the players accept the degree of creative expression they have? Will the audience enjoy the sound they make? The conductor may have a clear determining influence on all of these questions.

2.4. Leadership Qualities

Studies of leadership have suggested qualities that people often associate with leadership. They include:

- Technical/specific skill at some task at hand
- Charismatic inspiration - attractiveness to others and the ability to leverage this esteem to motivate others

• Preoccupation with a role - a dedication that consumes much of leaders' life - service to a cause

• A clear sense of purpose (or mission) - clear goals - focus - commitment

• Results-orientation - directing every action towards a mission - prioritizing activities to spend time where results most accrue

• Cooperation – work well with others

• Optimism - very few pessimists become leaders

• Rejection of determinism - belief in one's ability to "make a difference"

• Ability to encourage and nurture those that report to them - delegate in such a way as people will grow

• Role models - leaders may adopt a persona that encapsulates their mission and lead by example

• Self-knowledge (in non-bureaucratic structures)

• Self-awareness - the ability to "lead" (as it were) one's own self prior to leading other selves similarly

• Awareness of environment - the ability to understand the environment they lead in and how they affect and are affected by it.

With regards to people and to projects, the ability to choose winners - recognizing that, unlike with skills, one cannot (in general) teach attitude. Note that "picking winners" ("choosing winners") carries implications of gamblers' luck as well as of the capacity to take risks, but "true" leaders, like gamblers but unlike "false" leaders, base their decisions on realistic insight (and usually on many other factors partially derived from "real" wisdom).

• Empathy – Understanding what others say, rather than listening to how they say things - this could partly sum this quality up as "walking in someone else's shoes"

• Integrity – the integration of outward actions and inner values.

• Sense of Humour– people work better when they're happy.

In 2008 Burman published a ***'charter' for leaders***:

1. Leading by example in accordance with the company’s core values.
2. Building the trust and confidence of the people with which they work.
3. Continually seeking improvement in their methods and effectiveness.
4. Keeping people in formed.
5. Being accountable for their actions and holding others accountable for theirs.
6. Involving people, seeking their views, listening actively to what they have to say and representing these views honestly.

7. Being clear on what is expected, and providing feedback on progress.

8. Showing tolerance of people's differences and dealing with their issues fairly.

9. Acknowledging and recognizing people for their contributions and performance.

10. Weighing alternatives, considering both short and long-term effects and then being resolute in the decisions they make.

Different models of leadership

The approach of listing leadership qualities, often termed "trait theory of leadership", assumes certain traits or characteristics will tend to lead to effective leadership. Although trait theory has an intuitive appeal, difficulties may arise in proving its tenets, and opponents frequently challenge this approach. The "strongest" versions of trait theory see these "leadership characteristics" as innate, and accordingly labels some people as "born leaders" due to their psychological makeup. On this reading of the theory, leadership development involves identifying and measuring leadership qualities, screening potential leaders from non-leaders, then training those with potential.

David McClelland saw leadership skills, not so much as a set of traits, but as a pattern of motives. He claimed that successful leaders will tend to have a high need for power, a low need for affiliation, and a high level of what he called activity inhibition (one might call it self-control).

Situational leadership theory offers an alternative approach. It proceeds from the assumption that different situations call for different characteristics. According to this group of theories, no single optimal psychographic profile of a leader exists. The situational leadership model of Hersey and Blanchard, for example, suggest four leadership-styles and four levels of follower-development. For effectiveness, the model posits that the leadership-style must match the appropriate level of followership-development. In this model, leadership behavior becomes a function not only of the characteristics of the leader, but of the characteristics of followers as well. Other situational leadership models introduce a variety of situational variables. These determinants include:

- the nature of the task (structured or routine);
- organization policies, climate, and culture;
- the preferences of the leader's superiors;
- the expectations of peers;
- the reciprocal responses of followers.

The contingency model of Vroom and Yetton uses other situational variables, including:

- the nature of the problem;
- the requirements for accuracy;

- the acceptance of an initiative;
- time-constraints;
- cost-constraints.

However one determines leadership behavior, one can categorize it into various leadership styles. Many ways of doing this exist. For example, the Managerial Grid Model, a behavioral leadership-model, suggests five different leadership styles, based on leaders' strength of concern for people and their concern for goal achievement.

Kurt Lewin identified three leadership styles: authoritarian, democratic, and laissez-faire, based on the amount of influence and power exercised by the leader.

The Fiedler contingency model bases the leader’s effectiveness on what Fred Fiedler called situational contingency. This results from the interaction of leadership style and situational favorableness (later called "situational control").

2.5. Leadership "styles" – criteria of leadership

In 1994 House and Podsakoff attempted to summarize the behaviors and approaches of "outstanding leaders" that they obtained from some more modern theories and research findings. These leadership behaviors and approaches do not constitute specific styles, but cumulatively they probably characterize the most effective style of leaders/managers of the time. The listed leadership "styles" cover:

1. Vision. Outstanding leaders articulate an ideological vision congruent with the deeply-held values of followers, a vision that describes a better future to which the followers have an alleged moral right.
2. Passion and self-sacrifice. Leaders display a passion for, and have a strong conviction of, what they regard as the moral correctness of their vision. They engage in outstanding or extraordinary behavior and make extraordinary self-sacrifices in the interest of their vision and mission.
3. Confidence, determination, and persistence. Outstanding leaders display a high degree of faith in themselves and in the attainment of the vision they articulate. Theoretically, such leaders need to have a very high degree of self-confidence and moral conviction because their mission usually challenges the status quo and, therefore, may offend those who have a stake in preserving the established order.
4. Image-building. House and Podsakoff regard outstanding leaders as self-conscious about their own image. They recognize the desirability of followers perceiving them as competent, credible, and trustworthy.
5. Role-modeling. Leader-image-building sets the stage for effective role-modeling because followers identify with the values of role models whom they perceived in positive terms.

6. External representation. Outstanding leaders act as spokespersons for their respective organizations and symbolically represent those organizations to external constituencies.

7. Expectations of and confidence in followers. Outstanding leaders communicate expectations of high performance from their followers and strong confidence in their followers' ability to meet such expectations.

8. Selective motive-arousal. Outstanding leaders selectively arouse those motives of followers that the outstanding leaders see as of special relevance to the successful accomplishment of the vision and mission.

9. Frame alignment. To persuade followers to accept and implement change, outstanding leaders engage in "frame alignment". This refers to the linkage of individual and leader interpretive orientations such that some set of followers' interests, values, and beliefs, as well as the leader's activities, goals, and ideology, becomes congruent and complementary.

10. Inspirational communication. Outstanding leaders often, but not always, communicate their message in an inspirational manner using vivid stories, slogans, symbols, and ceremonies.

Even though these ten leadership behaviors and approaches do not really equate to specific styles, evidence has started to accumulate that a leader's style can make a difference. Style becomes the key to the formulation and implementation of strategy and plays an important role in work-group members' activity and in team citizenship. Little doubt exists that the way (style) in which leaders influence work-group members can make a difference in their own and their people's performance

Leadership and vision

Many definitions of leadership involve an element of Goal management|vision— except in cases of involuntary leadership and often in cases of traditional leadership. A vision provides direction to the influence process. A leader or group of leaders can have one or more visions of the future to aid them to move a group successfully towards this goal. A vision, for effectiveness, should allegedly:

- appear as a simple, yet vibrant, image in the mind of the leader
- describe a future state, credible and preferable to the present state
- act as a bridge between the current state and a future optimum state
- appear desirable enough to energize followers
- succeed in speaking to followers at an emotional or spiritual level (logical appeals by themselves seldom muster a following)

For leadership to occur, according to this theory, some people "leaders" must communicate the vision to others "followers" in such a way that the followers adopt the vision as their own. Leaders must not just see the vision themselves, they must have the ability to get others to see it also. Numerous techniques aid in this process, including: narratives, metaphors, symbolic actions, leading by example, incentives, and penalty|penalties.

Stacey (1992) has suggested that the emphasis on vision puts an unrealistic burden on the leader. Such emphasis appears to perpetuate the myth that an organization must depend on a single, uncommonly talented individual to decide what to do. Stacey claims that this fosters a culture of dependency and conformity in which followers take no pro-active incentives and do not think independently.

Kanungo's charismatic leadership model describes the role of the vision in three stages that are continuously ongoing, overlapping one another. Assessing the status quo, formulation and articulation of the vision, and implementation of the vision.

Leadership and emotions

Leadership can be perceived as a particularly emotion-laden process, with emotions entwined with the social influence process. In an organization, the leaders' mood has some effects on his group. These effects can be described in 3 levels:

1. The mood of individual group members. Group members with leaders in a positive mood experience more positive mood than do group members with leaders in a negative mood. The leaders transmit their moods to other group members through the mechanism of mood contagion. Mood contagion may be one of the psychological mechanisms by which charismatic leaders influence followers.

2. The affective tone of the group. Group affective tone represents the consistent or homogeneous affective reactions within a group. Group affective tone is an aggregate of the moods of the individual members of the group and refers to mood at the group level of analysis. Groups with leaders in a positive mood have a more positive affective tone than do groups with leaders in a negative mood.

3. Group processes like coordination, effort expenditure, and task strategy. Public expressions of mood impact how group members think and act. When people experience and express mood, they send signals to others. Leaders signal their goals, intentions, and attitudes through their expressions of moods. For example, expressions of positive moods by leaders signal that leaders deem progress toward goals to be good. The group members respond to those signals cognitively and behaviorally in ways that are reflected in the group processes.

In research about client service it was found that expressions of positive mood by the leader improve the performance of the group, although in other sectors there were another findings.

Beyond the leader's mood, his behavior is a source for employee positive and negative emotions at work. The leader creates situations and events that lead to emotional response. Certain leader behaviors displayed during interactions with their employees are the sources of these affective events. Leaders shape workplace affective events. Examples –feedback

giving, allocating tasks, resource distribution. Since employee behavior and productivity are directly affected by their emotional states, it is imperative to consider employee emotional responses to organizational leaders. Emotional intelligence, the ability to understand and manage moods and emotions in the self and others, contributes to effective leadership in organizations.

Leadership's relation with management

Some commentators link leadership closely with the idea of management. Some regard the two as synonymous, and others consider management a subset of leadership. If one accepts this premise, one can view leadership as:

- Centralized or decentralized;
- Broad or focused;
- decision-oriented or morale-centered;
- intrinsic or derived from some authority.

Any of the bipolar labels traditionally ascribed to management style could also apply to leadership style. Hersey and Blanchard use this approach: they claim that management merely consists of leadership applied to business situations; or in other words: management forms a sub-set of the broader process of leadership. They put it this way: "Leadership occurs any time one attempts to influence the behavior of an individual or group, regardless of the reason. Management is a kind of leadership in which the achievement of organizational goals is paramount."

However, a clear distinction between management and leadership may nevertheless prove useful. This would allow for a reciprocal relationship between leadership and management, implying that an effective manager should possess leadership skills, and an effective leader should demonstrate management skills. One clear distinction could provide the following definition:

Management involves power by position.

Leadership involves power by influence.

Abraham Zaleznik (1977), for example, delineated differences between leadership and management. He saw leaders as inspiring visionaries, concerned about substance; while managers he views as planners who have concerns with process. Warren Bennis (1989) further explicated a dichotomy between managers and leaders. He drew twelve distinctions between the two groups:

- Managers administer, leaders innovate;
- Managers ask how and when, leaders ask what and why;
- Managers focus on systems, leaders focus on people;
- Managers do things right, leaders do the right things;
- Managers maintain, leaders develop;
- Managers rely on control, leaders inspire trust;

- Managers have a short-term perspective, leaders have a longer-term perspective;
- Managers accept the status-quo, leaders challenge the status-quo;
- Managers have an eye on the bottom line, leaders have an eye on the horizon;
- Managers imitate, leaders originate;
- Managers emulate the classic good soldier, leaders are their own person;
- Managers copy, leaders show originality.

Leadership by a group

In contrast to individual leadership, some organizations have adopted group leadership. In this situation, more than one person provides direction to the group as a whole. Some organizations have taken this approach in hopes of increasing creativity, reducing costs, or downsizing. Others may see the traditional leadership of a boss as costing too much in team performance. In some situations, the maintenance of the boss becomes too expensive - either by draining the resources of the group as a whole, or by impeding the creativity within the team, even unintentionally.

A common example of group leadership involves cross-functional teams. A team of people with diverse skills and from all parts of an organization assembles to lead a project. A team structure can involve sharing power equally on all issues, but more commonly uses rotating leadership. The team member(s) best able to handle any given phase of the project become(s) the temporary leader(s). According to Ogbonnia (2007), "effective leadership is the ability to successfully integrate and maximize available resources within the internal and external environment for the attainment of organizational or societal goals". Ogbonnia defines an effective leader "as an individual with the capacity to consistently succeed in a given condition and be recognized as meeting the expectations of an organization or society."

Criticism of the concept of leadership

Noam Chomsky has criticized the concept of leadership as involving people subordinating their needs to that of someone else. While the conventional view of leadership is rather satisfying to people who "want to be told what to do", one should question why they are being subjected to acts that may not be rational or even desirable. Rationality is the key element missing when "leaders" say "believe me" and "have faith". It is fairly easy to have people simplistically follow you as their "leader", if no attention is paid to rationality.

Moving to the public domain-presidents, senators, people in congress-such positions are dubbed as leaders. In this domain, representatives ARE desirable NOT "leaders". The representative simply take the view of the group being represented and help to move forward with these objectives. If

they don't follow what the representatives have asked, they should easily be removed and replaced. Ask yourself when the last time such a system of representation existed! When "leaders" in the form of politicians come to town there is a parade of celebration and cheering without any room for such rationality but plenty of room for empty rhetoric and in some cases a rock star status. People need to ask themselves why they would want leaders, given the brutal history of such unaccountable people, and not representatives.

References:

1. Heifetz, R. (1994). Leadership without easy answers. Cambridge, MA: Harvard University Press.
2. Maxwell, J. C. & Dornan, J. (2003) Becoming a Person of Influence
3. Laubach, R. (2005) Leadership is Influence
4. Pitcher, P. (1994 French) Artists, Craftsmen, and Technocrats: The dreams realities and illusions of leadership, Stoddart Publishing, Toronto, 2nd English edition, 1997
5. Warneka, T. (2006). Leading People the Black Belt Way: Conquering the Five Core Problems Facing Leaders Today. AsogomiPublicationsIntl. Cleveland, Ohio. Website.

Topics of reports, abstracts and creative projects

1. Leadership as combine psychological process.
2. Contradictoriness of leadership process.
3. Leadership style and traits of leader.
4. The democratic leader and creativity.
5. The autocratic leader and aggressiveness.
6. Liberal leader and game.
7. Responsible leader, effective and emotional (psychological) one – is it one or three?
8. Optimism as leadership quality.
9. Communication and influence as criteria of leadership.
10. Knowledge, experience and intelligence – the most important criteria of leadership.

3. ORGANIZATION OF THE COMMUNICATION PROCESS IN HEALTH SERVICE

3.1. Principles of effective communication in health service (neutral, competent, ethical, credible, and equitable).

3.2. Communication between the health organization and its environment.

3.3. Communication between levels and units.
3.4. Health communication models.
3.5. Organization of the communication process. Elements and stages of the communication process. Coding and selection of the communication channel. Information transfer and decoding. Feedback and interference.
3.6. Barriers to interpersonal communication.
3.7. Factors to increase communicative activity.

3.1. Principles of effective communication in the health sector (neutral, competent, ethical, credible, equitable)

Principles of effective communication in health service:

− neutral and competent.

Effective communication on health issues occurs in a relatively simple and understandable language. It is based on facts, i.e. On available scientific data. With its help, people receive truthful and useful information on health issues and behavioral skills that promote health. Communication aimed at health savings forms public opinion, which has a significant impact on the adoption of certain decisions to preserve and promote public health. Communication in the field of health does not pursue commercial goals, but it can use advertising tools and a commercial partnership to enhance the effectiveness of information impact.

− ethical and credible.

All information is based on the results of scientific research or on experience that can be trusted. All sources of information are called directly, and goals and content should not conflict with the principles of healthy lifestyle. Possible cooperation with commercial structures should be open and adhere to the directions of the existing state policy in the field of health service. Commercial advertising should not be confused with information based on scientific research.

− equitable.

Effective communication, dedicated to health issues, takes into account the differences in the health status of the population, caused by socio-economic reasons. Channels of communication, content and language should be chosen in such a way that the essence of the message reaches all representatives of the target group, incl. And those whose health is most at risk. For example, it is difficult for people who abuse alcohol or the homeless to convey information through the media, they need direct contact.

3.2. Communication between the health service organization and its environment

Virtually everything that surrounds a person, what makes up his environment is also a communicative environment. "The word heals" - this well-known truth leads to thinking about exactly how it happens and how to

work with the word. The conversation between the doctor and the patient should not take place spontaneously, otherwise fatal accidents are possible (as in the well-known comic book, the patient, misunderstanding the doctor's words, decided that he had only one month to live).

The doctor and the patient, being equal participants in the treatment and diagnostic process, are nonetheless unequal. The specific relationship between the doctor and the patient is determined by the fact that one of them is sick, the other is healthy, one of them depends on his desire to recover from the other. A doctor's word for a patient is not only the word of a specialist; a centuries-old practice of medicine is for a doctor. The doctor has considerable expert authority, followed by a powerful influence of tradition. Poor communication from the physician is the main factor leading to dissatisfaction of the patient and his relatives with the treatment.

In the opinion of A.V. Reshetnikov, medicine as a social institution should be considered as a set of roles of doctors and patients common to all medical organizations. The social role of the physician is initially at a higher level of hierarchy regarding the role of the patient; together these roles form a kind of managerial "vertical".

Inequality of the doctor and the patient necessitates the successful course of the medical process of the presence in the doctor of certain personal qualities, such as sensitivity, responsiveness, sincerity, benevolence, politeness. Due to these qualities, the doctor remains the leading figure in medicine with all its computerization and technical equipment. Even in the ancient manuscripts of Ayurveda it was pointed out that one could be afraid of the father, mother, friends, teacher, but there should be no fear of a doctor who should be kinder and more attentive to the patient. In 1836 I.E. Dyadkovsky asserted: "The most important means, in which sufferers need, is the moral power of persuasion." G.A. Zakharyin said: "There is no need to explain the difficult situation in which a doctor is located, to whom there is no trust; the situation of the patient, who has to be treated by a doctor, to whom there is no trust, is even more difficult." At the end of the twentieth century, I.V. Bogorad: "There is hardly a profession that would be so lucky as a doctor, from the point of view of society's attention to it. This is understandable. After all, in the hands of a doctor a person is born, on his hands goes into oblivion. "

According to the prominent English psychiatrist M. Balint: "The doctor is in itself a remedy, you only need to take into account the" dosage "and" side effect "of his personality."

V. Veresaev wrote that a doctor can have a tremendous talent, be able to catch the finest details of his appointments, but all this will remain fruitless if he does not have the ability to subjugate and subjugate the patient's soul. Even great people sometimes like to obey the development of the disease.

There are two types of relationships in the "doctor-patient" communication system:

1 - authoritarian-directive position of the doctor - leads to passivity of the patient,

2 - "the principle of partnership", respect for the patient's personality, an empathic attitude.

Training in communication skills helps physicians to act more effectively in particularly "sensitive" aspects of doctor-patient relationships, which are often encountered in practice. Effective communications are especially important in the face of extremely limited times for medical advice. In conditions of very intense admission of patients in outpatient facilities (polyclinics), the introduction of effective communications should be considered as a very serious factor and as a strategy designed to alleviate these difficulties.

3.3. Communication between levels and units

The art and success of business communication are largely determined by the norms and principles that the manager uses in relation to his subordinates: what kind of behavior in service is acceptable and which is not. These rules are applicable to certain types of communication: "top-down" (leader-subordinate), "bottom-up" (subordinate-manager) and "horizontally" (employee-employee).

In communications "from top to bottom", i.e. In relation to the leader to a subordinate, the "golden rule" of ethics can be formulated as follows: "Treat your subordinate in the way that you would like to be treated by a leader." The art and success of business communication are largely determined by the norms and principles that the leader uses in relation to his subordinates.

Communication "bottom-up". Knowing how to handle and treat your supervisor is just as important as what demands should be placed on your subordinates. Without this it is difficult to find a common language with both the boss and the subordinates. Using these or other norms, you can attract a leader to your side, make your ally, but you can also set it against yourself, make it your ill-wisher.

Communications "horizontally". The general ethical principle of communication "horizontally", i.e. Between colleagues (managers or ordinary members of the group). With regard to fellow managers should be borne in mind that finding the right tone and acceptable standards of business communication with peer-to-peer employees from other departments is a very difficult matter. Especially when it comes to communication and relationships within one organization. In this case, they are often rivals in the struggle for success and promotion. At the same time, these are people who

together with you belong to the team of the general manager. Participants in business communication should feel equal in relation to each other.

3.4. Health communication models

In the course of the historical development of medicine, there were three main paradigms of the formation of medical problems that subordinate the process of communication "doctor-patient" and determine its features.

The first. Treatment of the patient at his location, when directly at home, depending on the personal qualities of the patient, the doctor formed certain therapeutic tasks. Personal contact ensured the patient's perception of the patient as an integrated psychosomatic community, in which physical and emotional disorders are inseparable. The main purpose of the doctor's communication with the patient was to identify specific patient problems in order to solve them on the spot.

The second. With the development of hospital medicine, the paradigm of the formation of medical problems is changing. With the advent of hospitals, a number of patients enter the doctor's office at once, with the diseases being separated from individuals. The doctor gradually lost interest in the unique qualities of man as a whole, and it is replaced by comparative studies of specific organ damage and functional disorders in different people in different states.

The third. With the advent and development of laboratory medical research, "communication" with the patient has shifted to the field of chemical-physiological processes. The disease began to be perceived as a deviation of these processes from the norm, which is subject to explanation in accordance with the inexorable laws of natural science. Quickly and the patient, and then the doctor, were forced out of the system of forming medical tasks. Despite the extensive use of laboratory and instrumental methods in modern clinical medicine, communication between the doctor and the patient plays a huge role in the treatment and diagnostic process.

The success of the communication process determines the formation of trust in the doctor, represents the basis for the successful implementation of the medical service ("word treatment").

Often patients, assessing the quality of medical services provided to a healthcare organization, are guided by the consumer aspects that are accessible to their understanding: proximity to the place of residence, the timeliness of the provision of medical care, and, of course, the attitude of medical personnel.

Qualification of the doctor is often estimated by patients on deontological aspects. The patient's non-tactical attitude to the patient, formal communication with him, negatively affects the process of doctor-patient interaction and correlates with the patient's negative assessment of the activities of the healthcare organization as a whole.

American expert on medical ethics R. Witch distinguishes four models of the relationship between a doctor and a patient:

1. A model of a technical type: the doctor behaves like a "plumber who connects the pipes and flushes the clogged systems without suffering any moral issues."

2. A model of the sacred type that emerges as a counterbalance to the first model, which turns the doctor into a "priest who cares more for the soul than for the body."

3. A model of the collegial type assumes that the doctor and patient should see each other in their colleagues, striving for the common goal of eliminating the disease and protecting the patient's health. The decisive role belongs to trust. This model is also called consultative, based on trust and mutual consent. In the case of a low level of competence of the patient (low educational level) the model of the collegial type functions in the form of an interpretation model (the convincing doctor).

4. The contractual model is based on a contract or agreement. It allows you to avoid rejection of both the moral standards on the part of the doctor (as in the technical model) and the moral expectations of the patient (as in the model of the sacred type). This model is based on informed consent of the patient, and it is the patient who is ultimately free to control his or her destiny.

A contractual model is also called information, when a dispassionate doctor works with a completely independent patient.

In the practice of domestic health service, models of technical and sacral type are practically not found in pure form. A model of contract type is also rare for Belarus. Domestic medical practice has developed two main models of relationships in the "doctor-patient" system:

1. Paternalistic model - the doctor not only assumes the duties of the patient, but also independently decides what exactly this good consists of. Exclusively in the competence of the doctor is the decision, what information about the patient's condition and treatment tactics to provide. Thus, the freedom of the patient's personality is significantly limited.

2. The autonomous model proceeds from the patient's autonomy principle, according to which all medical activity is built on the basis of an equitable dialogue with the patient. To inform the patient is the duty of the doctor (informed consent principle).

According to medico-sociological research, doctors mainly implement the event-based model of informed consent, when, after assessing the patient's condition and informing him, the doctor makes a diagnosis and makes a plan for the examination (treatment). Patients are also attuned to a procedural model of informed consent, based on the fact that making a medical decision is a long process and the exchange of information should go on throughout the entire time the doctor interacts with the patient.

An autonomous model of doctor-patient relationships is enshrined in the health service legislation of the Republic of Belarus. Nevertheless, the full use of the autonomous model in practice is limited by the competence of patients depending on the level of general culture, psychoemotional state, medical literacy, the degree of patient's awareness of their own condition, etc. It is impossible to apply an autonomous model in situations that directly threaten the patient's life and require immediate Medical intervention: emergency surgery, resuscitation. Therefore, in the practice of public health, a third, borderline model of doctor-patient relationships is singled out:

3. The model of weakened paternalism - allows partial restriction of individual freedom in those cases when the autonomy of the latter is reduced. For example, this happens when it is necessary to keep the patient from causing himself or other significant harm (mental illness, drug addictive hallucinations, etc.), as well as in pediatric practice.

According to the Russian authors, when choosing the model of relationships in the "doctor-patient" system, the technical model is least preferable for patients, the second place "from the end" was a contractual model, followed by a paternalistic model, and the collegial model was the most preferable. Doctors, as well as patients, considered the model of the technical type to be the least used, but it is characteristic that doctors with a small (less than 10 years) experience used a model of a technical type 2 times more likely than their experienced colleagues. The contractual model was also not popular with doctors (in second place "from the end", as in patients, young doctors preferred it more often). The next most frequent use was the paternalistic model, and the most popular was the collegiate model. At the same time, the collegial model was limitedly used in surgical practice due to insufficient and incorrect, in the opinion of doctors, awareness of patients. Analysis of the survey data of doctors showed that doctors believe that they provide patients with a sufficient amount of information. At the same time, this opinion largely contradicts their claims about the completeness of patient information: according to the answers of doctors (especially surgeons), three quarters of patients are not informed or insufficiently informed, and half of the patients are informed incorrectly. The authors also found that about 67% of patients in one way or another resort to self-treatment, which is due to their lack of awareness. The positions of doctors and patients on the need for information did not coincide: doctors believe that they provide the information in sufficient volume, patients deny it and resort to various information sources (primarily to the media) and subsequent self-treatment.

Declaring adherence to the collegial model of doctor-patient interaction, a number of doctors, primarily surgeons, are in practice oriented towards a paternalistic model of interaction. Characteristic for surgical specialties, the danger of referring the patient as a person to the background is noted by foreign authors. The studies of T. Blisener and J. Sigrist showed

that in surgical departments the average duration of the bypass is 48 seconds to 3 minutes. In this case, the doctor makes about 40 statements, the patient - about 25, the rest of the medical staff (among themselves) - about 15. Much of what the patient says is a response to the doctor's initiatives, so that during the bypass the patient can ask only one question. D. Haque and F. De Boer note that a large number of operations and a lack of time form an "anatomical" approach to the patient and do not facilitate the establishment of contact. At the same time, doctors of outpatient clinics, due to the short duration of outpatient reception, are prone to automatic work, which also does not contribute to creating a contact between the doctor and the patient.

3.5. Organization of the communication process. Elements and stages of the communication process. Coding and selection of the communication channel. Information transfer and decoding. Feedback and interference

1. The origin of the idea.

The sender's formation of ideas, the selection of information, the formulation of the meaning or the meaning of why and what to transfer to another participant in the process.

The source of the message. Communicator - the creator of the message. The source can be a person, an organization, a group of individuals or an individual transmitting this message.

Codes are symbols or signs (this is the speech itself) that translates the message into a language that the recipient understands. Verbal and non-verbal means of communication are used as codes.

A message is information or an encoded idea, i.e. What the source transmits to the recipient. Messages consist of signs of various kinds (verbal and non-verbal).

A communicant (recipient, addressee, recipient) is a person, or a group of persons, the mass audience to which the message is sent.

2. Coding and channel selection. Coding is the transformation of a transmitted message into a message or signal that can be transmitted to ensure optimal signal transmission over a certain communication channel. The sender must encode the idea with the help of symbols (words, intonation or gestures). This coding turns the idea into a message. Well-known channels include the transmission of speech and written materials, electronic means of communication, including computer networks, e-mail, videotapes and videoconferences. The exchange of information will not be effective if the communication channel does not correspond to the idea that has arisen. It is desirable that the choice of the means of transmitting the message is not limited to one channel. The transmission of information, for example, using the means of exchange of oral and written information is usually more effective than, say, only the exchange of written information.

3. Transfer. In the third stage, the sender uses a channel to deliver a message (an encoded idea or a set of ideas) to the recipient. As soon as the transmission of the message or signal began, the communication process goes out of the control of the medium or the person who sent it. You can not return a sent message back.

The stage begins to receive the transmitted information and to understand its meaning. The person to whom the message was addressed is called the recipient. This is another key role performed by a participant in interpersonal communication in order for the process to take place. The role of the recipient is not only to fix the receipt of the message, but also to decode this message in an understandable and acceptable meaning for it.

4. Decoding. Decoding is the translation of the sender's symbols into the recipient's thoughts. It includes the perception (the receipt) of the message by the recipient, its interpretation (as understood) and evaluation (as and how it was accepted). The transmitted information must be adequately perceived by the recipient. For this, the encoding and decoding is closed in a single circuit. If the symbols selected by the sender have exactly the same value for the recipient, the latter will know what the sender was thinking when his idea was formulated. Thus, the communicant must be able to: quickly highlight the subject matter of information for keywords; Correctly interpret the beginning of the message and, therefore, anticipate its deployment; Restore the meaning of the message, despite the missing elements; Correctly determine the intent of the utterance.

However, there are reasons why the recipient can give the message a slightly different meaning than the one the sender invested.

Feedback and interference. Before discussing various obstacles to the exchange of information, it is necessary to learn two important concepts - feedback and interference. Feedback is a reaction to what has been heard, seen or read.

When feedback is received, information is sent back to the sender, indicating a measure of understanding, trust in the message, assimilation and agreement with the message. Effective information exchange should be bilaterally directed: feedback is necessary to understand the extent to which the message was perceived and understood. The main thing in the communication process is not just the exchange of information between two or more people, but the exchange of meaning, the content of information. Feedback increases the chances of an effective exchange of information.

Interference is any interference in the communication process at any of its sites, distorting the meaning of the message. Sources of interference can be language, differences in perception, because of which the meaning changes when encoding and decoding. Certain interference is always present. And therefore at each stage of the process of information exchange there is some distortion of meaning. A high level of interference will definitely lead

to a noticeable loss of meaning and can completely block the attempt to establish information exchange.

The communicative process is a necessary prerequisite for the emergence, development and functioning of all social systems, because it provides the link between people and their communities, enables intergenerational communication, facilitates the accumulation and transfer of social experience, its enrichment, the distribution of labor and the exchange of its products, Organization of joint activities, cultural broadcasting.

3.6. Barriers to interpersonal communication

Any distortion of information is called noise. Source noise + receiver's noise = semantic. Semantic noise is the misuse of language / other symbols (foreigners), it is a subjective interpretation of linguistic or other symbols. Mechanical noise is the channel noise that is associated with technical information loss due to channel imperfection, technical problems in coding and decoding.

Barriers to communication are interference that interferes with the implementation of contacts and interaction between the communicator and the recipient. They interfere with adequate reception, understanding and assimilation of messages in the process of communication.

Technical interference. The source of such interference is the communication channel itself (fax, telephone) and its technical malfunctions.

Psychological interferences are related to the relationship between the communicator and the recipient, their attitudes to the information channel, the methods, content and form of the message.

Psychophysiological disturbances arise due to sensory abilities, peculiarities of human perception, the ability of the human brain to remember and process information.

Language interference occurs on the phonetic and semantic level. On the phonetic - because of the indistinguishability of sounds, poor pronunciation, rejection of the tempo of speech, and on the semantic - due to a lack of understanding of the indicated meaning.

Social hindrances are expressed in the belonging of communicants to different social groups, they are caused by social norms, prohibitions, restrictions in obtaining information.

Cultural and national interference. Features in international communications are due to differences in traditions, norms, values, evaluation of various forms of communication, reaction to information received.

Incorrect or incomplete understanding of the content of the message can be caused both by the insufficiency and redundancy of the information contained in the message. Insufficiency of information is supplemented by the application of repeated requests or is thought out, completed. The

problems of information overloads are solved by regulating, filtering, queuing messages. Reducing the distortion of information is also facilitated by the elimination of intermediaries in information flows.

3.7. Factors to increase communicative activity

The effect of communication - changes in the behavior of the communicant, which occur as a result of receiving the message. The effect can be positive (communication is successful) and negative (when the set goals the communicator could not be reached). Reducing any communication barriers increases the effect of communication. The effectiveness of intra-organizational communication depends on many factors that can be divided into two large groups - individual and organizational.

Individual factors of increasing the effectiveness of communications are factors related to the employees of the organization, their ability and motivation to participate in communications and achieve the goal of communication, as well as the reduction of interpersonal communication barriers.

To individual factors of increasing the effectiveness of communications can be attributed:

- increase the communicative competence of employees;
- choosing the most suitable interpersonal channel for the communicant;
- close attitudes and knowledge at the source and the addressee.

Organizational factors for increasing the effectiveness of communications are factors related to the structure and processes in the organization:

- regulation of information flows, both in the interaction of the organization with the external environment, and within the organization; It should be remembered that environmental factors affecting the organization's activities determine the organization's external communication needs, but at the same time, discussions, meetings, telephone conversations, memos sent and reports are in many ways a reaction to opportunities or problems ,created by the external environment;
- creation of feedback systems, including management actions that contribute to the formation of upstream and side (horizontal) branches of information exchange, the creation of systems for the collection of proposals; Perform the function of informing the management of what is being done at the lower levels, about current or emerging problems, suggests possible options for correcting the state of affairs; For example, the creation of groups of employees who meet regularly to discuss and solve problems in the production or maintenance of consumers; The exchange of information but ascending usually occurs in the form of reports, proposals and explanatory notes;

- distribution of informative materials for application within the organization, many organizations use e-mail for this, large organizations can have special editions that contain information for all employees, including articles reviewing proposals for management, public health topics, a new species Medicinal products or medical services, which is scheduled to offer consumers in the near future, management responses to the questions of ordinary employees;
- application of the achievements of modern information technology contributes to the improvement of information exchange in organizations, because accelerates many processes.

Using a number of factors to improve the effectiveness of communications

Some factors affecting the effectiveness of communications	Possible ways to improve the efficiency of business communications
1. Increase the communicative competence of communication participants	Study theory; trainings, business games conducted on the basis of theoretical knowledge, as well as practical experience of business communications and analysis of the constructiveness of communications
2. The right choice of an interpersonal communication channel: -channel of direct communication face to face;	It is best suited for the transmission of ambiguous messages that require clarification, as well as non-standard, information-intensive messages.
-interactive communication channel;	The phone, electronic communication types speed up communication, these are the fastest channels. Suitable for information-intensive messages, but somewhat less voluminous and multivalued than in the previous channel.
-personal written communication channels;	Notes, letters, etc. - suitable for relatively large, but not overloaded information messages.
-impersonal written communication channels.	Reports, bulletins, etc. - suitable for routine, clear, simple messages.
3. Improvement of the organization of the communication process.	Establishment, constant support and control of feedback. Reduction of possible communication barriers. Regulation of information flows.
4. Accounting for the characteristics of the recipient of information: -the presence of expectations, needs, features of perception;	If communication with expectations coincides with the needs of recipients of information, it is effective.
-attitudes and knowledge at the source and the addressee;	If there is a mismatch, you need preliminary preparation, additional communications.

–understanding of the objectives of the activity, the existing interrelations and problems, the requirements of a particular situation	An understanding of the way of thinking, the perception of employees
5. Planning and preliminary preparation of complex, problem communications.	Preliminary analysis of available information, development of options for mutually acceptable solutions, drawing up of a plan of speech, meeting, negotiations, etc.

Factors increasing the communicative effectiveness of the "doctor-patient":

1. The physician belongs to a real "authoritative" group.
2. Attractiveness of the appearance of the doctor (neat hair, combed, whether ironed, shaved, buttoned on all buttons, etc.).
3. Benevolent attitude to the addressee of the impact (to the patient) (smile, friendliness, ease of handling, etc.).
4. Competence of a specialist.
5. Sincerity, and, if the listener trusts the speaker, he very well perceives and remembers the conclusions and practically does not pay attention to the course of reasoning. If there is less confidence, then to the conclusions it is cooler, but very attentive to the arguments and the course of reasoning.

Topics of reports, abstracts and creative projects

1. Ways to establish a healthy moral climate in a medical team.
2. Ways to improve communicative effectiveness in the doctor-patient dyad.
3. Historical forms of models of the relationship between the doctor and the patient.
4. The paternalism of the doctor: the pluses, minuses.

4. MAIN PRINCIPALS OF EFFECTIVE INTERPERSONAL COMMUNICATION

4.1.Verbal and nonverbal communications
4.2. Barriers to effectiveness of communication
4.3. Effective communication
4.4. Medical (Doctor-Patient) communication
4.5. Improvement of Communication skills

Communication (from Latin commūnicāre, meaning "to share") is the act of conveying intended meanings from one entity or group to another through the use of mutually understood signs and semiotic rules.

Communication happens at many levels (even for one single action), in many different ways, and for most beings, as well as certain machines. Several, if not all, fields of study dedicate a portion of attention to communication, so when speaking about communication it is very important to be sure about what aspects of communication one is speaking about. Definitions of communication range widely, some recognizing that animals can communicate with each other as well as human beings, and some are more narrow, only including human beings within the parameters of human symbolic interaction.

- Communication is a process that allows organisms to exchange information by several methods.
- Communication is the articulation of sending a message, whether it be verbal or nonverbal, so long as a being transmits a thought provoking idea, gesture, action, etc.
- Communication can be defined as the process of meaningful interaction among human beings. It is the act of passing information and the process by which meanings are exchanged so as to produce understanding.
- Communication is the process by which any message is given or received through talking, writing, or making gestures.

There are auditory means, such as speaking, singing and sometimes tone of voice, and nonverbal, physical means, such as body language, sign language, paralanguage, touch, eye contact, or the use of writing.

Nonetheless, communication is usually described along a few major dimensions:

1. Content (what type of things are communicated).
2. Source/Emisor/Sender/Encoder (by whom).
3. Form (in which form).
4. Channel (through which medium).
5. Destination/Receiver/Target/Decoder (to whom).
6. Purpose/Pragmatic aspect.

Communication may be defined as a process concerning exchange of facts or ideas between persons holding different positions in an organization to achieve mutual harmony. The communication process is dynamic in nature rather than a static phenomenon.

Communication process as such must be considered a continuous and dynamic inter-action, both affecting and being affected by many variables.

The main steps inherent to all communication are:

1. The forming of communicative motivation or reason.
2. Message composition (further internal or technical articulation on what exactly to express).

3. Message encoding (for example, into digital data, written text, speech, pictures, gestures and so on).

4. Transmission of the encoded message as a sequence of signals using a specific channel or medium.

5. Noise sources such as natural forces and in some cases human activity (both intentional and accidental) begin influencing the quality of signals propagating from the sender to one or more receivers.

6. Reception of signals and reassembling of the encoded message from a sequence of received signals.

7. Decoding of the reassembled encoded message.

8. Interpretation and making sense of the presumed original message.

The scientific study of communication can be divided into:

- Information theory which studies the quantification, storage, and communication of information in general;
- Communication studies which concerns human communication;
- Biosemiotics which examines communication in and between living organisms in general.

The channel of communication can be visual, auditory, tactile (such as in Braille) and haptic, olfactory, electromagnetic, or biochemical.

Human communication is unique for its extensive use of abstract language. Development of civilization has been closely linked with progress in telecommunication.

4.1. Verbal and nonverbal communication

Nonverbal communication between people is communication through sending and receiving wordless clues.

It includes the use of visual cues such as body language (kinesics), distance (proxemics) and physical environments/appearance, of voice (paralanguage) and of touch (haptics). It can also include chronemics (the use of time) and oculesics (eye contact and the actions of looking while talking and listening, frequency of glances, patterns of fixation, pupil dilation, and blink rate).

Just as speech contains nonverbal elements known as paralanguage, including voice quality, rate, pitch, volume, and speaking style, as well as prosodic features such as rhythm, intonation, and stress, so written texts have nonverbal elements such as handwriting style, spatial arrangement of words, or the physical layout of a page. However, much of the study of nonverbal communication has focused on interaction between individuals [2], where it can be classified into three principal areas: environmental conditions where communication takes place, physical characteristics of the communicators, and behaviors of communicators during interaction.

Nonverbal communication involves the conscious and unconscious processes of encoding and decoding. Encoding is the act of generating information such as facial expressions, gestures, and postures. Decoding is the interpretation of information from received sensations from previous experiences. [2]

Only a small percentage of the brain processes verbal communication. As infants, nonverbal communication is learned from social-emotional communication, making the face rather than voice the dominant communication channel. As children become verbal communicators, they begin to look at facial expressions, vocal tones, and other nonverbal elements more subconsciously.

Nonverbal communication represents two-thirds of all communication. Nonverbal communication can portray a message both vocally and with the correct body signals or gestures. Body signals comprise physical features, conscious and unconscious gestures and signals, and the mediation of personal space. The wrong message can also be established if the body language conveyed does not match a verbal message.

Nonverbal communication strengthens a first impression in common situations like attracting a partner or in a business interview: impressions are on average formed within the first four seconds of contact. First encounters or interactions with another person strongly affect a person's perception. When the other person or group is absorbing the message, they are focused on the entire environment around them, meaning the other person uses all five senses in the interaction: 83% sight, 11% hearing, 3% smell, 2% touch and 1% taste.

Verbal communication is the spoken or written conveyance of a message. Human language can be defined as a system of symbols (sometimes known as lexemes) and the grammars (rules) by which the symbols are manipulated. The word "language" also refers to common properties of languages. Language learning normally occurs most intensively during human childhood. Most of the thousands of human languages use patterns of sound or gesture for symbols which enable communication with others around them. Languages tend to share certain properties, although there are exceptions. There is no defined line between a language and a dialect.

The progression of **written communication** can be divided into three "information communication revolutions":

1. Written communication first emerged through the use of pictographs. The pictograms were made in stone, hence written communication was not yet mobile. Pictograms began to develop standardized and simplified forms.
2. The next step occurred when writing began to appear on paper, papyrus, clay, wax, and other media with common shared writing systems, leading to adaptable alphabets. Communication became mobile.

3. The final stage is characterized by the transfer of information through controlled waves of electromagnetic radiation (i.e., radio, microwave, infrared) and other electronic signals.

Communication is thus a process by which meaning is assigned and conveyed in an attempt to create shared understanding. Gregory Bateson called it "the replication of tautologies in the universe. This process, which requires a vast repertoire of skills in interpersonal processing, listening, observing, speaking, questioning, analyzing, gestures, and evaluating enables collaboration and cooperation.

4.2. Barriers to effectiveness of communication

Barriers to effective communication can retard or distort the message and intention of the message being conveyed which may result in failure of the communication process or an effect that is undesirable. These include filtering, selective perception, information overload, emotions, language, silence, communication apprehension, gender differences and political correctness.

This also includes a lack of expressing "knowledge-appropriate" communication, which occurs when a person uses ambiguous or complex legal words, medical jargon, or descriptions of a situation or environment that is not understood by the recipient.

Physical barriers – Physical barriers are often due to the nature of the environment. An example of this is the natural barrier which exists if staff are located in different buildings or on different sites. Likewise, poor or outdated equipment, particularly the failure of management to introduce new technology, may also cause problems. Staff shortages are another factor which frequently causes communication difficulties for an organization.

System design **–** System design faults refer to problems with the structures or systems in place in an organization. Examples might include an organizational structure which is unclear and therefore makes it confusing to know whom to communicate with. Other examples could be inefficient or inappropriate information systems, a lack of supervision or training, and a lack of clarity in roles and responsibilities which can lead to staff being uncertain about what is expected of them.

Attitudinal barriers **–** Attitudinal barriers come about as a result of problems with staff in an organization. These may be brought about, for example, by such factors as poor management, lack of consultation with employees, personality conflicts which can result in people delaying or refusing to communicate, the personal attitudes of individual employees which may be due to lack of motivation or dissatisfaction at work, brought about by insufficient training to enable them to carry out particular tasks, or simply resistance to change due to entrenched attitudes and ideas.

Ambiguity of words/phrases – Words sounding the same but having different meaning can convey a different meaning altogether. Hence the communicator must ensure that the receiver receives the same meaning. It is better if such words are avoided by using alternatives whenever possible.

Individual linguistic ability – The use of jargon, difficult or inappropriate words in communication can prevent the recipients from understanding the message. Poorly explained or misunderstood messages can also result in confusion. However, research in communication has shown that confusion can lend legitimacy to research when persuasion fails.

Physiological barriers – These may result from individuals' personal discomfort, caused – for example – by ill health, poor eyesight or hearing difficulties.

Bypassing – These happens when the communicators (sender and the receiver) do not attach the same symbolic meanings to their words. It is when the sender is expressing a thought or a word but the receiver take it in a different meaning. For example- ASAP, Rest room.

Technological multi-tasking and absorbency – With a rapid increase in technologically-driven communication in the past several decades, individuals are increasingly faced with condensed communication in the form of e-mail, text, and social updates. This has, in turn, led to a notable change in the way younger generations communicate and perceive their own self-efficacy to communicate and connect with others. With the ever-constant presence of another "world" in one's pocket, individuals are multi-tasking both physically and cognitively as constant reminders of something else happening somewhere else bombard them.

Fear of being criticized – This is a major factor that prevents good communication. If we exercise simple practices to improve our communication skill, we can become effective communicators. For example, read an article from the newspaper or collect some news from the television and present it in front of the mirror. This will not only boost your confidence, but also improve your language and vocabulary.

Gender barriers – Most communicators whether aware or not, often have a set agenda. This is very notable among the different genders. For example, many women are found to be more critical in addressing conflict. It's also been noted that men are more than likely to withdraw from conflict when in comparison to women. This breakdown and comparison not only shows that there are many factors to communication between two specific genders, but also room for improvement as well as established guidelines for all.

4.3. Effective communication

Listening is perhaps the most important of all interpersonal skills. Effective listening is very often the foundation of strong relationships with others, at home, socially, in education and in the workplace. Listening Types:

The two main types of listening – the foundations of all listening sub-types are:

- ***Discriminative Listening***
- ***Comprehensive Listening***

The three main types of listening most common in interpersonal communication are:

- ***Informational Listening*** **(**Listening to Learn**)**;
- ***Critical Listening*** **(**Listening to Evaluate and Analyze**);**
- ***Therapeutic or Empathetic Listening*** **(**Listening to Understand Feeling and Emotion).

In reality you may have more than one goal for listening at any given time – for example, you may be listening to learn whilst also attempting to be empathetic.

- **Informational Listening**

Whenever you listen to learn something, you are engaged in informational listening. This is true in many day-to-day situations, in education and at work, when you listen to the news, watch a documentary, when a friend tells you a recipe or when you are talked-through a technical problem with a computer – there are many other examples of informational listening too.

Although all types of listening are ‘active’ – they require concentration and a conscious effort to understand. Informational listening is less active than many of the other types of listening. When we are listening to learn or be instructed we are taking in new information and facts, we are not criticizing or analyzing. Informational listening, especially in formal settings like in work meetings or while in education, is often accompanied by note taking – a way of recording key information so that it can be reviewed later.

- **Critical Listening** We can be said to be engaged in critical listening when the goal is to evaluate or scrutinise what is being said. Critical listening is a much more active behavior than informational listening and usually involves some sort of problem solving or decision-making. Critical listening is akin to critical reading; both involve analysis of the information being received and alignment with what we already know or believe. Whereas informational listening may be mostly concerned with receiving facts and/or new information – critical listening is about analyzing opinion and making a judgement.

Therapeutic or Empathic Listening

Empathic listening involves attempting to understand the feelings and emotions of the speaker – to put yourself into the speaker's shoes and share their thoughts.

Empathy is a way of deeply connecting with another person and therapeutic or empathic listening can be particularly challenging. Empathy is not the same as sympathy, it involves more than being compassionate or feeling sorry for somebody else – it involves a deeper connection – a realization and understanding of another person's point of view.

Counsellors, therapists and some other professionals use therapeutic or empathic listening to understand and ultimately help their clients. This type of listening does not involve making judgements or offering advice but gently encouraging the speaker to explain and elaborate on their feelings and emotions. Skills such as clarification and reflection are often used to help avoid misunderstandings.

We are all capable of empathic listening and may practice it with friends, family and colleagues. Showing empathy is a desirable trait in many interpersonal relationships – you may well feel more comfortable talking about your own feelings and emotions with a particular person. They are likely to be better at listening empathetically to you than others, this is often based on similar perspectives, experiences, beliefs and values – a good friend, your spouse, a parent or sibling for example.

Although usually less important or useful in interpersonal relationships there are other types of listening, these include:

Appreciative Listening

Appreciative listening is listening for enjoyment. A good example is listening to music, especially as a way to relax. (See our page: Music Therapy for more about using music as a relaxation therapy).

Rapport Listening

When trying to build rapport with others we can engage in a type of listening that encourages the other person to trust and like us. A salesman, for example, may make an effort to listen carefully to what you are saying as a way to promote trust and potentially make a sale. This type of listening is common in situations of negotiation.

Selective Listening

This is a more negative type of listening, it implies that the listener is somehow biased to what they are hearing. Bias can be based on preconceived ideas or emotionally difficult communications. Selective listening is a sign of failing communication – you cannot hope to understand if you have filtered out some of the message and may reinforce or strengthen your bias for future communications.

Active listening is a skill that can be acquired and developed with practice. However, active listening can be difficult to master and will, therefore, take time and patience to develop.

'Active listening' means, as its name suggests, actively listening. That is fully concentrating on what is being said rather than just passively 'hearing' the message of the speaker.

Active listening involves listening with all senses. As well as giving full attention to the speaker, it is important that the 'active listener' is also 'seen' to be listening – otherwise the speaker may conclude that what they are talking about is uninteresting to the listener.

Interest can be conveyed to the speaker by using both verbal and non-verbal messages such as maintaining eye contact, nodding your head and smiling, agreeing by saying 'Yes' or simply 'Mmm hmm' to encourage them to continue. By providing this 'feedback' the person speaking will usually feel more at ease and therefore communicate more easily, openly and honestly.

Listening is not something that just happens (that is hearing), listening is an active process in which a conscious decision is made to listen to and understand the messages of the speaker.

Listeners should remain neutral and non-judgmental, this means trying not to take sides or form opinions, especially early in the conversation. Active listening is also about patience – pauses and short periods of silence should be accepted.

Listeners should not be tempted to jump in with questions or comments every time there are a few seconds of silence. Active listening involves giving the other person time to explore their thoughts and feelings, they should, therefore, be given adequate time for that.

Active listening not only means focusing fully on the speaker but also actively showing verbal and non-verbal signs of listening.

Generally, speakers want listeners to demonstrate 'active listening' by responding appropriately to what they are saying. Appropriate responses to listening can be both verbal and non-verbal, examples of which are listed below:

Signs of Attentive or Active Listening

- Positive Reinforcement. Although a strong signal of attentiveness, caution should be used when using positive verbal reinforcement. Although some positive words of encouragement may be beneficial to the speaker the listener should use them sparingly so as not to distract from what is being said or place unnecessary emphasis on parts of the message. Casual and frequent use of words and phrases, such as: '*very good*', '*yes*' or '*indeed*' can become irritating to the speaker. It is usually better to elaborate and explain why you are agreeing with a certain point.

- Remembering. The human mind is notoriously bad at remembering details, especially for any length of time. However, remembering a few key points, or even the name of the speaker, can help to reinforce that the messages sent have been received and understood – i.e. listening has been

successful. Remembering details, ideas and concepts from previous conversations proves that attention was kept and is likely to encourage the speaker to continue. During longer exchanges it may be appropriate to make very brief notes to act as a memory jog when questioning or clarifying later.

- Questioning. The listener can demonstrate that they have been paying attention by asking relevant questions and/or making statements that build or help to clarify what the speaker has said. By asking relevant questions the listener also helps to reinforce that they have an interest in what the speaker has been saying.
- Reflection. Reflecting is closely repeating or paraphrasing what the speaker has said in order to show comprehension. Reflection is a powerful skill that can reinforce the message of the speaker and demonstrate understanding.
- Clarification. Clarifying involves asking questions of the speaker to ensure that the correct message has been received. Clarification usually involves the use of open questions which enables the speaker to expand on certain points as necessary.
- Summarization. Repeating a summary of what has been said back to the speaker is a technique used by the listener to repeat what has been said in their own words. Summarizing involves taking the main points of the received message and reiterating them in a logical and clear way, giving the speaker chance to correct if necessary.

4.4 Medical (Doctor-Patient) Communication

Effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which is the heart and art of medicine. This is important in the delivery of high-quality health care. Much patient dissatisfaction and many complaints are due to breakdown in the doctor-patient relationship. However, many doctors tend to overestimate their ability in communication.

A doctor's communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients. These are the core clinical skills in the practice of medicine, with the ultimate goal of achieving the best outcome and patient satisfaction, which are essential for the effective delivery of health care.

Basic communication skills in isolation are insufficient to create and sustain a successful therapeutic doctor-patient relationship, which consists of shared perceptions and feelings regarding the nature of the problem, goals of treatment, and psychosocial support. Interpersonal skills build on this basic communication skill. Appropriate communication integrates both patient- and doctor-centered approaches.

The ultimate objective of any doctor-patient communication is to improve the patient's health and medical care. Studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent.

Doctors tend to overestimate their abilities in communication. 75% of the orthopedic surgeons surveyed believed that they communicated satisfactorily with their patients, but only 21% of the patients reported satisfactory communication with their doctors. Patient surveys have consistently shown that they want better communication with their doctors.

Good doctor-patient communication has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations. Patients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment. Patients' agreement with the doctor about the nature of the treatment and need for follow-up is strongly associated with their recovery.

There are **many barriers** to good communication in the doctor-patient relationship, including patients' anxiety and fear, doctors' burden of work, fear of litigation, fear of physical or verbal abuse, and unrealistic patient expectations.

1. Deterioration of Doctors' Communication Skills

It has been observed that communication skills tend to decline as medical students progress through their medical education, and over time doctors in training tend to lose their focus on holistic patient care. Furthermore, the emotional and physical brutality of medical training, particularly during internship and residency, suppresses empathy, substitutes techniques and procedures for talk, and may even result in derision of patients.

2. Nondisclosure of Information

The doctor-patient interaction is a complex process, and serious miscommunication is a potential pitfall, especially in terms of patients' understanding of their prognosis, purpose of care, expectations, and involvement in treatment. These important factors may affect the choices patients make regarding their treatment and end-of-life care, which can have a significant influence on the disease. Good communication skills practiced by doctors allowed patients to perceive themselves as a full participant during discussions relating to their health.

3. Doctors' Avoidance Behavior

There are reported observations of doctors avoiding discussion of the emotional and social impact of patients' problems because it distressed them

when they could not handle these issues or they did not have the time to do so adequately. This situation negatively affected doctors emotionally and tended to increase patients' distress. This avoidance behavior may result in patients being unwilling to disclose problems, which could delay and adversely impact their recovery.

4. Discouragement of Collaboration

Physicians have been found to discourage patients from voicing their concerns and expectations as well as requests for more information. This negative influence of the doctors' behavior and the resultant nature of the doctor-patient communication deterred patients from asserting their need for information and explanations. Patients can feel disempowered and may be unable to achieve their health goals. Lack of sufficient explanation results in poor patient understanding, and a lack of consensus between doctor and patient may lead to therapeutic failure.

5. Resistance by Patients

Today, patients have recognized that they are not passive recipients and are able to resist the power and expert authority that society grants doctors. They can implicitly and explicitly resist the monologue of information transfer from doctors by actively reconstructing expert information to assert their own perspectives, integrate with their knowledge of their own bodies and experiences, as well as the social realities of their lives.

4.5 Improvement of communication skills

Communication skills involve both style and content. Attentive listening skills, empathy, and use of open-ended questions are some examples of skillful communication. Improved doctor-patient communication tends to increase patient involvement and adherence to recommended therapy; influence patient satisfaction, adherence, and health care utilization; and improve quality of care and health outcomes.

Breaking bad news to patients is a complex and challenging communication task in the practice of medicine. Relationship building is especially important in breaking bad news. Important factors include understanding patients' perspectives, sharing information, and patients' knowledge and expectations. Miscommunication has serious implications, as it may hinder patients' understanding, expectations of treatment, or involvement in treatment planning. In addition, miscommunication decreases patient satisfaction with medical care, level of hopefulness, and subsequent psychological adjustment.

1. Communication Training

Doctors are not born with excellent communication skills, as they have different innate talents. Instead they can understand the theory of good doctor-patient communication, learn and practice these skills, and be capable

of modifying their communication style if there is sufficient motivation and incentive for self-awareness, self-monitoring, and training. Communication skills training has been found to improve doctor-patient communication. However, the improved behaviors may lapse over time. It is therefore important to practice new skills, with regular feedback on the acquired behavior. Some have said that medical education should go beyond skills training to encourage physicians' responsiveness to the patients' unique experience.

2. Collaborative Communication

Collaborative communication is a reciprocal and dynamic relationship, involving the 2-way exchange of information. In an ideal world, doctors should collaborate with their patients to provide the best care because doctors tend to make decisions based on quick assessments, which may be biased. This requires the doctors to take time or set up opportunities to offer and discuss treatment choices to patients and share the responsibility and control with them. Successful information exchange ensures that concerns are elicited and explored and that explanations of treatment options are balanced and understood to allow for shared decision making. In this approach, the doctor facilitates discussion and negotiation with patients and the treatment options are evaluated and tailored to the context of the patients' situation and needs, rather than a standardized protocol. Care options need to be collaborative between doctor and patient, taking into account patient expectations, outcome preferences, level of risk acceptance, and any associated cost to maximize adherence and to assure the best outcome.

3. Conflict Management

4. Health Beliefs

Beliefs and values affect the doctor-patient relationship and interaction. Divergent beliefs can affect health care through competing therapies, fear of the health care system, or distrust of prescribed therapies. This perception gap may negatively affect treatment decisions and therefore may influence patient outcomes despite appropriate therapy. Although doctors use a biomedical model to understand illness, patient beliefs and values are influenced by social and behavioral factors as well as biology or anatomy.

It is important to identify and address perceived barriers and benefits of treatment to improve patient adherence to medical plans by ensuring that the benefits and importance of treatment are understood. Doctors should understand patients' functional meaning of disease, as well as the relationship meaning and symbolic meaning, followed by a summary of this information and telling the patient the problem from the doctor's perspective and, finally, asking the patient to summarize what was said. Agreement between doctor and patient is a key variable that influences outcome.

References:

1. Trenholm, Sarah; Jensen, Arthur (2013). Interpersonal Communication Seventh Edition. NewYork: OxfordUniversityPress. pp. 360–361.

2. Robbins, S., Judge, T., Millett, B., & Boyle, M. (2011). OrganisationalBehaviour. 6th ed. Pearson, French's Forest, NSW p315-317.

3. Barnlund, D. C. (2008). A transactional model of communication. In. C. D. Mortensen (Eds.), Communication theory (2nd ed., pp47-57). NewBrunswick, NewJersey: Transaction.

4. Roy M. Berko, et al., Communicating. 11th ed. (Boston, MA: Pearson Education, Inc., 2010) 9-12.

Topics of reports, abstracts and creative projects

1. Verbal channel in communication.
2. Nonverbal communication as rich source of important information about your partner.
3. Active listening as art of comprehension.
4. The silence is gold!
5. Different tips of good conversation.
6. Interpersonal communication and feedback.
7. Types of doctor-patient’s communication.
8. Improvement of communication skills.

5. METHODS OF FORMING COMMUNICATION SKILLS

5.1. General principles of effective communication. Formation and development of communication skills.

5.2. Verbal and non-verbal means of communication with the patient.

5.3. The main psychological determinants of the development of the communicative competence of a doctor.

5.4. Basic communication skills of doctor-patient relationships.

5.5. Medical interview and basic communication skills.

5.1. General principles of effective communication. Formation and development of communication skills

The effectiveness of the communication process in interpersonal communications is determined by a number of factors, among which the following are the main ones.

− Perception: people perceive the same information in different ways. The perception of information is influenced by the addressee's competence, experience, interests, social attitudes, emotional state, and the context in which this information was transmitted. Therefore, information is perceived by people selectively. The communicative process with

interpersonal communication is influenced by the degree of openness, trust, bias.

− Poor feedback: inaccuracies that arise in the understanding of transmitted information through fault of differences in perception, semantic inaccuracies or misinterpreted non-verbal symbols are eliminated with qualitative feedback. Low-quality feedback leads to disruption of interpersonal communications.

− Poor listening. Loss of communication between the doctor and the patient is often due to the transfer of the conversation into a professional space that the patient does not understand. For example, a patient emotionally describes his illness, and the doctor, quickly determining what happened to the patient, simply states the diagnosis or pronounces a specific medical term. As a result, the patient, as it were, loses touch with what he is talking about, and turns into an outside observer. At the same time, the doctor, sometimes unconsciously, emphasizes the advantage of his social role. Investigating the frequency of interruptions, it can be concluded that often doctors simply do not listen to the patient.

There are three types of listening habits:

1) an attentive listener who correctly assesses the situation, creates an atmosphere of conversation, disposes the interlocutor to the utterance;

2) a passive listener whose external and internal indifference to the conversation causes apathy in the interlocutor and unwillingness to continue communication;

3) an aggressive listener, verbally and nonverbally contributing to the emergence of a reciprocal aggressive reaction in the interlocutor.

Keith Davis cites 10 rules-manuals on art to effectively listen, successfully used in the practice of management: 1) stop talking; 2) help the speaker to be liberated; 3) show the speaker that you are ready to listen; 4) eliminate the annoying moments; 5) empathize with the speaker; 6) be patient, do not save time; 7) restrain your character; 8) do not allow disputes or criticism; 9) ask questions; 10) stop talking. The first and tenth instruction in this list are the same, for the author claims that it is the ability to listen effectively - the basis for the success of communication.

Key skills in effective health communication include the following rules:

- communicate effectively and clearly with patients, staff, colleagues in the transmission and receipt of targeted messages;
- allow patients to communicate effectively;
- efficiently listen when there is not enough time, namely at the beginning and end of the conversation;
- Identify potential communication difficulties and work until results are achieved;

- understand how to use and receive nonverbal signals in the body language;
- use oral, written and electronic communication methods;
- know when the information received should be transferred to another person / professional for action;
- recognize the need for further development in acquiring communication skills.

If a person avoids, evades contact with the interlocutor, or makes every effort not to perceive the message (inattentive, does not listen, does not look at the interlocutor, uses any pretext to stop the conversation), then two interrelated problems must be resolved: 1. draw attention; 2. To keep attention.

Attention is most influenced by the following factors: the relevance and importance of information, its novelty, non-standard submission, unexpectedness, the intensity of information transfer, sonority of voice and its modulation.

You can attract attention by using 3 basic techniques:

1. Reception of the "neutral phrase". At the beginning of the talk, the conversation is pronounced a phrase that is not directly related to the main topic, but for any reasons meaningful, meaningful, valuable to the interlocutor or to all those present (from where, the last viewed film, the television program, the book, hobbies, etc. .);

2. Reception of "enticement". The speaker utters something that is difficult to perceive, for example, speaks very quietly, monotonously or indistinctly, and the listener has to make special efforts to understand something. These efforts also involve concentration of attention. As a result, the speaker "lures" the listener into his "networks". In other words, the speaker provokes the listener himself to apply methods of concentration of attention, and then uses them;

3. Reception of "eye contact". The speaker looks around the audience, looks intently at someone, selects several people in the audience and nods to them, etc.

Equally important is the problem of maintaining attention. It is solved by a number of techniques. The most important of them are as follows:

− reception of "isolation" (when the interlocutor is taken away, secluded, closes doors and windows, makes comments to the speakers);

− reception of "imposing the rhythm" (constant change in the characteristics of voice and speech, ie, speaking louder, then quietly, then faster, then slower, then more expressively, "with pressure", then tongue-tied, then neutral, the speaker, as it were, imposes the interlocutor Its sequence of switching attention). This method eliminates the monotony of sound;

– receiving "accentuation" (the use of various official phrases designed to attract attention, such as "Please pay attention", "It is important to note that ...", "It must be stressed that ...", etc.).

The frame in communication creates the beginning and end of the conversation. For the effectiveness of communication, it is expedient to first indicate the goal, prospects and expected results of communication, and at the end of the conversation - to sum up, to show the retrospective, to note the degree of achievement of the goals. And in the primary communication the most important part is the beginning, and with repeated business communication - the end of the conversation. In the second case, people are not so interested in how the negotiations, the conversation, were going on, like what they ended up with. The chain rule is based on the assumption that the content of communication can not be a formless heap of various information, it must somehow be built, connected in a chain, "listed". Any chain, ordering, linking, organizing content, like a frame, performs two tasks at once: first, it improves memorization; second, it helps to structure the information in accordance with the expectations of the interlocutor.

The problem of logical misunderstanding arises, if a person, from our point of view, speaks or does something in contradiction with the rules of logic; Then we not only refuse to understand him, but also emotionally perceive his words negatively. At the same time, we implicitly assume that logic is only one - the correct one, i.e. our. However, it's no secret that there are different logics: women's, children's, age, etc. Each person thinks, lives and acts according to his logic, but in communication, unless these logics are correlated or if a person does not have a clear idea of the partner's logic, a barrier of logical misunderstanding arises.

What is important to remember the doctor in the communication process?

1. Doctors often forget that the open space of the hospital room allows patients from neighboring beds to hear the stories of other patients. When interviewing patients, the relationship of trust should be developed consistently.

2. Observance of confidentiality is an important condition that the doctor should not forget about in the communication process. In most cases, one-to-one conversations are not a problem. Problems arise when people want to discuss issues related to other people, usually relatives ("I'm very concerned about my sister, so I wanted to see you"). You must decide where a reasonable discussion goes beyond disclosure. A guarantee of secrecy is necessary for the patient. In this case, the doctor should remain polite, but firm ("Obviously, I cannot discuss this further without permission from A.").

3. Avoid medical terminology. Patients may not understand medical terminology and, even worse, use medical concepts incorrectly. Use words

that the patient will understand! Words can have different meanings in different contexts.

5.2. Verbal and non-verbal means of communication with the patient

Communicative means differ in nature by the following types:

1**.** ***verbal communication*** (verbal) - words, phrases that form verbal systems;

2. ***nonverbal communication***, which form non-verbal systems:

− communication by means of signs;

− communication with gestures;

− communication by means of symbols (alphabetic, digital, graphic, color);

− communication with other paralinguistic means (for example, facial expressions, postures, body movements, voice features (height, volume, tone, etc.).

Verbal communication uses human speech as a sign system. Speech is a universal means of communication, since the transmission of information through speech is the least likely to lose the meaning of the message. When using speech from 100% conceived the communicator expresses about 80%. In the event that there is no interference during the transmission of the message, the recipient takes about 60%, based on the features of his attention. The perception of the meaning of the above is about 50% and only 40% of the speech information is acquired. This circumstance requires intensive use of the feedback mechanism in verbal communication.

The model of the verbal communicative process includes ***5 elements***:

WHO? (Sends a message) - Communicator

WHAT? (Transmitted) - Message (text)

AS? (Transfer is in progress) - Channel

WHO? (Message sent) - Audience

WITH WHAT EFFECT? - Effectiveness

The main purpose of verbal communication of a doctor is to establish, maintain, develop meaningful information contact with the patient.

Types of verbal communication:

Written: the certainty of the source; Constancy of information; The possibility of an adequate report.

Oral: non-verbal reinforcement is possible; Can be edited and clarified. The information can be subject (depending on the subject) and modal (it shows whether what is said is essential, desirable, necessary, possible). The oral communication involves such forms as monologue, dialogue and polylogue.

The monologue can pursue several goals: inform the listeners (informative speech - report, address at the meeting, report), awaken certain

feelings and emotions (persuasive speech - advertising, solemn speech, congratulatory, memorial, etc.), induce them to certain actions (speech Protest, political speech). Monologic speech is always public, most often pronounced with a large crowd of people - at meetings, conferences, congresses, etc. A monologue is not just a speech for listeners, but primarily for listeners. The speaker presents both the text and himself to the audience, monitors the reaction of listeners and makes adjustments during the performance in the light of the changing situation. At the same time, the position of the listeners is complicated, because according to etiquette they should remain silent throughout the speech and do not interfere with the speaker's speech. Listeners express, silently linguistically and psychologically, with the help of non-verbal or paralinguistic means, the attitude to what the speaker says. A grateful or bored look, dull heads or nodding nods, whistling and laughter, deathly silence, yawning, a buzz of displeasure, a thunder of applause, a demonstrative departure from the audience are signals of feedback, counteraction of the audience.

Dialogue as a form of verbal communication represents a process of mutual communication, when the change of the replicas reflects a constant change of initiative, roles: the speaker becomes a listener, and the listener - the speaker. Varieties of dialogic communication: everyday conversation, business conversation, interview, interview, negotiation, dispute. For example, a doctor's dialogue with a patient can have three options for dialogue:

1) the doctor asks questions and receives answers on the merits;

2) the doctor asks questions and receives vague answers;

3) the doctor asks questions and receives answers that are not relevant. The second variant of the dialogue is most typical, especially if the patient is not educated enough or is experiencing pain and embarrassment. With the third type of dialogue, physicians are faced when patients are painfully hypochondriac or seek to emphasize their erudition in the field of medicine.

The polylogist presupposes the presence of several active participants in verbal communication.

Types of oral communication: speaking and listening. In the course of special studies it was found that on average, a person spends 29.5% of the time for a hearing, 21.5% for speaking, 10% for a letter.

The process of speaking. The ability to speak, or oratorical art, was taught back in antiquity. It involves the ability to accurately formulate your thoughts, set them forth as available to your interlocutor, and orient yourself in communicating with the interlocutor. For successful communication it is necessary to master the basics of the culture of speech.

Types of speaking: monological and dialogical.

The doctor's speech in dealing with the patient should be aimed at convincing the interlocutor in his point of view and induce him to cooperate. Conviction is defined as psychological factors, the very atmosphere of the conversation, which can be favorable or unfavorable, benevolent or spiteful, and the culture of speech. The culture of speech communication includes, above all, fluency in the language. Any natural language has a complex structure (literary language, in which the language norm is expressed, vernacular, professional vocabulary, profanity). Speech culture in communication is expressed in assessing the level of thinking of the interlocutor, his life experience and in addressing the interlocutor in a language understandable to him. When talking, you need to use simple, clear and precise words, correctly formulate your thoughts. No wonder there is an expression "cuts hearing".

Statements without orientation to the interlocutor refer to the monologic type of speaking. The amount of loss of information under the monologue reaches 50%, and sometimes - and 80% of the volume of initial information, in connection with which, it is especially important to master the art of dialogic communication, whose resources are extremely wide and diverse. Dialogue is a method of knowing another person. Especially important is the ability to conduct a dialogue for a specialist of a helping profession, which includes the profession of a doctor. Dialogic communication involves the ability to ask questions that contribute to the maximum rapprochement of communication partners.

The hearing process (see below "active listening"). Inability to listen is the main reason for ineffective communication; it leads to misunderstandings, mistakes and problems. Some people think that listening is simply keeping quiet, but listening is a complex process that requires considerable psychological energy, certain skills and a common communicative culture.

Usually, speech refers to its oral and written varieties. However, the sound and graphic implementation of the language does not exhaust all possible manifestations of speech, to which a person is capable. Thus, deafborn people use finger fingerprint speech, blind people perceive written speech tactfully with the help of Braille's relief-dotted type, pierced in paper, and written using specially equipped instruments, squeezing the text with a slate.

In the system of communication with the patient, nonverbal communication is very important. It is connected with the mental states of man and serves as a means of expression. Non-verbal communication is spontaneous, unconscious. Nonverbal language shows the attitude to the partner in communication, what a person thinks and feels in reality, in contrast to verbal communication that represents factual information.

Nonverbal behavior of a person is polyfunctional:

− creates an image of a communication partner;

− expresses the relationship of partners in communication, forms these relations;

− is an indicator of a person's mental states;

− supplements speech, replaces speech, represents the emotional states of partners in the communication process;

− serves as a clarification, a change in the understanding of the verbal message, reinforces the emotional saturation of what has been said;

− maintains the optimal level of psychological intimacy between the interlocutors.

Non-verbal signals carry 5 times more information than verbal signals. Nonverbal communication is based on 5 basic sciences:

1) Paralinguistics is the science of the sound codes of non-verbal communication. Paralinguistic components are intensity, rhythm, tempo, pitch of sound. Extralinguistic components are individual features of pronunciation - speech pauses, laughter, sighs, crying, coughing, etc.

2) Kinesika - the science of gestures, gestures and facial expressions.

3) Oculist - the science of eye language and visual behavior of people during intercourse, "eye contact".

4) Tawes, or haptic, is the science of the language of touch and tactile communication.

5) Proxemics - the science of the space of communication, its structure and functions; the spatial position of the communicants, their placement relative to each other, is explored.

The ability to "read" the non-verbal message of the interlocutor is a professionally significant quality of the doctor (!), which allows more accurate diagnosis of the behavior of dissimulation, in which the patient deliberately hides the symptoms of his disease. Analysis of nonverbal behavior allows us to distinguish characteristic mimic reactions to pain, restrained gestures, static poses - signs that indicate the existence of a "protective" style of behavior: the minimum number of movements allows us to limit the effect of pain stimuli.

What are the rules of non-verbal communication desirable to comply with?

- Try to take a friendly, open posture when you are standing or sitting;
- Try not to intrude into the personal space and not to keep too much distance (about one meter to the right), although it may be different if inspection is conducting;
- Relax your shoulders, cervical and facial muscles;
- Try not to cross your arms across the trunk, because in this position you may appear defensive;
- Move a little forward to show that you are listening;

- Nod your head and encourage the patient with the smile to continue the conversation;

- Do not keep your back and shoulders too straight, because you may seem aggressive;

- Do not slouch, because you may seem bored or not interested.

5.3. The main psychological determinants of the development of the communicative competence of a doctor

In psychology, the criteria for effective communication are:

1) the ability to advance in solving the problems of communication participants;

2) ensuring the achievement of communication goals with optimal costs (the absence of neuropsychical overloads, adequate expenditure of psychological resources);

3) to achieve mutual understanding between partners in communication.

Correspondence of professional communication of the doctor with all these criteria will mean successful realization of the potential, which is incorporated in the communicative component of the doctor's activity.

Qualitative and professional medical care for the population has always been an urgent problem in any country in the world. It is multifaceted and depends on many circumstances. First, medical workers carry out their professional activity in conditions of a strict time limit, a lack of medicines and equipment, which clearly does not stimulate them to favorable communication with patients. Secondly, they do not aspire to show attention, care, empathy (compassion, empathy) towards patients and colleagues.

Communicative competence is one of the main characteristics of a doctor's professional competence; Begins to form during the period of study at the university and the process of independent professional communication with patients.

Also communicative competence is a certain level of the formation of interpersonal and professional experience of interaction with others, a necessary individual for successful functioning in the professional sphere and society.

Young doctors often unconsciously imitate, copy the style of behavior of those doctors-teachers, whose opinions are guided. And only in process of accumulation of experience of professional dialogue the doctor already consciously uses the skills facilitating his communication with patients ".

The communicative competence of the doctor, which underlies the establishment of a therapeutic alliance with the patient, allows:

− to recognize better and to respond correctly to verbal and non-verbal signs of patients and to extract more useful clinical information from them;

− to conduct more effective diagnostics, because the latter depends not only on the establishment of bodily symptoms of the disease, but also on the physician's ability to identify those somatic symptoms whose causes, while having a psychological or social nature, require, in turn, other treatment plans;

− to seek approval by the patient for the treatment plan because the patient's reluctance to follow prescribed treatment is the most serious problem in medicine;

− transfer adequate medical information to patients and reasonably convince them to lead a healthier lifestyle;

− to influence various forms of the disease (emotional, intellectual, motivational) and to activate compensatory mechanisms, to increase the psychosomatic potential of the patient's personality, to help him restore contact with the world, to overcome the so-called acquired or trained helplessness, to destroy the stereotypes formed by the disease;

− to act more effectively in sensitive situations, for example, if it is necessary to inform the patient that he is terminally ill, or tell the patient's relatives that he must die, etc.

A specialist in the field of medicine should not only ensure full communication and achieve positive changes in the doctor-patient dyad, but also maintain their own well-being.

To build successful professional communication, the developed self-awareness is of great importance, which provides an opportunity for effective reflection of one's communicative behavior and contributes to the development of the necessary methods for its correction. Here you can distinguish the possession of communication techniques, which include: the technique of establishing contact, active listening, drawing attention to the text of the message, the formation of a positive attitude to the continuation or repetition of contact, the technique of civilized psychological influence, and the technology of destroying psychological barriers.

As an integral characteristic of communicative behavior, success develops with age and the accumulation of knowledge of the specifics of communication, the acquisition and expansion of a range of social skills, the growth of confidence in oneself and its capabilities.

Among the psychological determinants of the communicative competence of a doctor, one can include unobserved and observed abilities of the subject of professional activity.

Unobservable abilities include flexibility in interpersonal communication, role flexibility, empathy, receptivity. Role flexibility allows the entry of a person into the role that a partner expects from him. Empathy and receptivity enable us to correctly assess ourselves, the partner and the situation. In the list of observed abilities fall: the ability to communicate, to cooperation, to conflict management and to work in a team.

An important component of the high level of communicative competence of the physician is the ability to interact effectively, jointly develop action plans and coordinate their professional activities with others, i.e. The ability to cooperate and coordinate, which includes a number of characteristics: initiative; Establishing contacts and trusting relationships; Ability to set joint goals, willingness to be responsible for the consequences of joint action.

Among the psychological characteristics of the development of communicative competence is the ability to manage conflicts arising during the performance of professional activities. This ability includes the timely identification of a conflict situation, an understanding of its possible causes and etymologies, the search for settlement methods, initiative and activity in the application of permit mechanisms. The ability to manage conflict lies in the conscious choice of conflict management methods and an adequate strategy of behavior.

Among the psychological determinants of the development of communicative competence are also specific skills: communicative, socially-perceptive, interactive. Among the communicative skills stand out: speech skills, the ability to receive feedback, overcome communication barriers. The group of interactive skills includes: the ability to build communication on a humane, democratic basis, to initiate a favorable emotional and psychological atmosphere, the ability to self-control and self-regulation, the ability to organize cooperation, the ability to follow the principles and rules of ethics and etiquette, and the skills of active listening. The socio-perceptual skills include: the ability to adequately perceive and evaluate the partner's behavior in communication, to recognize by non-verbal signals his state, desires and motives of behavior, the ability to produce a favorable impression.

To the significant determinants of the development of the necessary level of professional communicative competence is the personality quality as sociability - the need for other people and contacts with them, the desire for these contacts, their intensity and ease, as well as the person's ability to have friendly behavior in a situation of communication and establishing a trusting relationship , The desire to take the initiative in contact.

Thus, it is possible to single out a number of psychological determinants that produce the development of a high level of communicative competence of the doctor. In a generalized form, they can be combined into the following groups:

– socio-psychological: experience of interaction with competent people who broadcast optimal models of communicative behavior;

– personally significant, supporting the development of psychological culture in communication, incentives emanating from society;

– subjective: abilities that are relevant to communication, communicative socially-perceptive, interactive skills;

– skills of maintaining positive contact;

– self-realization and self-control skills;

– personal communication characteristics: sociability, contactness, flexibility, empathy, conflict management, teamwork.

Adequate communication requires a correct understanding of the patient and an appropriate response to his behavior. The patient's knowledge of his illness with the help of a doctor contributes to the success of the treatment. This is the most promising way of creating (for a doctor of any specialty) the patient has new dominants that have a health-improving effect. The physician must have emotional and intellectual flexibility, boldness of decisions and faith in his abilities. No behavior of the patient should interfere with treatment. The belief and conviction of the doctor is transmitted to the patient. Doctors often have to work in extreme conditions, in situations of risk, requiring the mobilization of physical and volitional forces.

5.4. Basic communication skills of doctor-patient relationship

Meeting with a doctor is one of the important moments of healing. Interpersonal communication is a complex, multifaceted process of establishing contacts between people. It is indispensable component of professional medical activity, when the doctor is often both a teacher and an educator.

The following basic communication skills of the doctor-patient relationship are singled out, which are among the main skills that allow creating effective partnerships. Training these skills should aim to achieve a basic level of competence.

Adequate material environment. The creation of an adequate material environment increases the degree of privacy, comfort and attention to the patient. Small details, such as the design of the place where the interviewee sits, create a sense of privacy and will contribute to the successful outcome of the interview.

Greeting patients will help maintain self-esteem, and encourage them to participate in the conversation. The use of the patient's name is appropriate when he is familiar with the doctor, while the doctor gives an appropriate signal that he recognized the interlocutor.

Active listening involves using both verbal and non-verbal communication techniques. The doctor should clearly signal that all his attention is focused on the patient and make it look, by sending signals indicating that the information is accepted (nodding, phrases like "true", "understand"). The desire to actively listen is best demonstrated through the use of open questions, which pushes the interlocutor to more complete answers. Listening requires certain skills that need to be trained. Everyone can learn to listen more effectively. An effective method of listening is the ability to listen "with your whole body." When a person is burning with a

special desire to hear something interesting, he says: "I'm all - attention." Unconsciously, he takes the appropriate pose: turns his face toward the speaker, establishes a visual contact with him, hears the interlocutor. Such a hearing with "the whole body" expresses a willingness to listen and helps the process of perception. This pose is an effective means of increasing the perception of the interlocutor's speech. Listening and perceiving means not being distracted, maintaining constant attention, steady visual contact and using the pose as a means of communication.

Empathy, respect, interest, warmth and support - these constituent parts are the core of interpersonal skills. Emotional complicity helps to establish psychological contact with the patient, to receive more complete and accurate information about him, about his condition, to inspire confidence in the competence of the doctor and the adequacy of the therapeutic and diagnostic process that he carries out, instill faith in recovery. Empathic qualities of the doctor can be useful in cases of inconsistency of the subjective signs of the symptoms presented to patients with an objective clinical picture of the disease: (with aggravation, dissimulation and anosognosia, and also in the case of simulated behavior).

Language. Doctors should also constantly monitor the degree of complexity of the language they use for their explanations, in particular in explaining the diagnosis and the causes that led to the disease, as well as suggestions about the treatment and the reasons for these suggestions.

The relationship of cooperation. It is important that the patient can feel that the doctor clearly understands his needs and is ready to work with the patient to meet them. This will happen if the treatment plan is the result of a thorough explanation of the opinions that have arisen and full awareness of the patient's needs, leading to an informed discussion of the conditions of this plan.

Closed interview. The physician should give a clear signal that the interview is moving to its completion, usually by summing up what was said and what was discussed during it (see below, "Medical interview and basic communication skills for conducting it).

The skills of collecting information are the main, decisive part of the relationship between the doctor and the patient. It consists in the ability to extract information from the patient. The main skills necessary to facilitate the process of collecting information are those that help the doctor to achieve the correct diagnosis of the symptoms or problems of the patient.

A very important and often ignored part of the information gathering skills is the doctor's ability to clarify the patient's problems and meet his expectations, in other words, to find out: why did the patient come to the doctor? In most cases it is assumed that the patient has come to be examined or treated, but often this is far from the case. The reasons for treatment can be diverse and bear the character not only medical, but psychological and social:

the desire to get a list of incapacity for work, the need to hear from the doctor a truthful answer, for example, the probability of a patient having a myocardial infarction or sudden death, the exchange of current medical information (especially in patients With a chronic pathology), the desire to discuss a family conflict or simply the need to pour out the soul, etc. It should be remembered that the patient's satisfaction with a meeting with a doctor is determined not by the doctor's qualification in general, but by whether the patient received what he was looking for in this meeting. Here lies the reason that many, from a medical point of view, flawlessly conducted receptions, patients leave them completely dissatisfied and vice versa.

Silence. It is necessary to learn the correct use of silence as a way to inspire the patient to speak as fully as possible, to touch upon complex topics and to recall important information. The ability to correctly pause in conversation and use silence is a skill largely creative and acquired intuitively. Do not be afraid of pauses in conversation - they often give more than words, and they are especially important in revealing the hidden, deep feelings of the patient. On the contrary, excessive verbosity of the doctor often serves as a manifestation of his unconscious protection from the patient's problems, to deal with which the doctor is absolutely not ready.

Control the flow of information. While giving patients the opportunity for free communication is important, but at the same time, the student must learn to be able to keep control of the interview in his hands by tactfully channeling the content of the conversation toward diagnosing the problem.

The final stage is the **summation** of the collected information and the advancement of a preliminary hypothesis (it may concern the definition of the nature of the disease, or its causes, or a plan for further action, etc.). Because During the consultation a large amount of information can be obtained, it is necessary to learn how to summarize the main data that arose during the consultation "also has to make sure that understanding of this is shared with him by his patient.

The most common mistakes are closed and leading questions at the beginning and open (which suggest an extended answer and which cannot be answered with "yes" or "no") - at the end of the interview, unclear expectations of the patient from the consultation and lack of summation of the collected information.

Thus, a doctor should be able to:

1. To create an adequate material environment to increase the degree of privacy, comfort and attention to the patient.

2. To be able to greet patients in a way that is acceptable according to cultural norms in accordance with their age, gender, etc. This will contribute to maintaining self-esteem and encourage patients to participate in the conversation.

3. Clearly signal that all of his attention is focused on the patient and by sending signals indicating that the information is being received and the contact should be continued (perhaps only a glance).

5.5. Medical interview and basic communication skills

Studies show that 60-80% of diagnostic decisions are made on the basis of information obtained only during a medical interview; The same proportion is noted when making therapeutic decisions. The basis of the medical interview is communication, and in itself medical interview is the basis of all medical practice. A medical interview is understood as any long-term communication between a doctor and his patient.

The most prominent domestic doctors always attached great importance to the process of elucidating the subjective and objective anamnesis. Zakharin G.A. He called it "the removal of a medical portrait". Anamnesis is a controlled conversation. It is not easy to make an anamnesis correctly. The patient should have the impression of a casual conversation. In this case, the doctor must assess the seriousness of complaints, the manner in which they are presented. It is important to be able to separate the main from the secondary, to verify the reliability of the testimony, without offending the patient with mistrust, to help remember. To be able to stealthily direct the conversation, not to let go of the non-essential details, extraneous topics. It requires creativity and creativity. In the process of familiarizing the patient with the doctor, his internal picture of the illness must come up with sensations and sufferings of both physical and mental order. It should be borne in mind that the very process of questioning is not only a recognition process for the doctor, but also the beginning of therapeutic treatment for the patient.

Unlike the usual synonym for "talking with a patient", the term "interview" emphasizes the presence of special skills and skills, as well as a pre-planned plan for conducting it.

Basic skills in the structure of medical interviews are divided into:

1) interpersonal skills,

2) the skills of collecting information,

3) skills of transferring information to the patient.

The components of the medical interview, as well as the most typical medical errors for each of these parts.

I stage. Establishment of "confidence distance". Situational support, provision of confidentiality guarantees. Determination of the dominant motives for interviewing.

II stage. Identifying complaints (passive and active interviews), evaluating the inner picture - the concept of the disease; structuring the problem.

III stage. Evaluation of the desired outcome of the interview and therapy; definition of the subjective model of the patient's health and preferential mental status.

IV stage. Evaluation of the patient's anticipated (predictive) abilities; discussion of possible variants of the outcome of the disease (if detected) and therapy.

Opening interview. The interview should begin with a doctor's greeting. The form of the greeting should correspond to the age and social experience of the patient. The verbal greeting needs to be backed up by non-verbal means - it can be a shaking of the hand, a slope of the body towards the patient, a nod of the head, a smile, etc. Otherwise, the patient perceives the greeting as unnatural and insincere. In case the patient is late for the reception, it is always necessary to find out the reason for this, because Delay is often an unconscious attempt to avoid a meeting.

The place where the patient should sit down should most often be indicated by the doctor. Only sometimes with a diagnostic purpose can the patient be given the opportunity to choose his own place and see how he does it: an anxious patient will try to hide behind any barrier, depressive will occupy the most uncomfortable and unprestigious seat, etc. Further, if this meeting is the first, the doctor should introduce himself to the patient. It is psychologically more correct to do this even if the name of the doctor is written on the door of the cabinet, in the registry, etc. It is important to remember that pronouncing a person's name, surname, position indistinctly and briefly indicates his low self-esteem and does not contribute to raising his status in the eyes of the interlocutor. Then follow the introductory comments - the doctor briefly describes how he imagines the purpose of the meeting, the main issues that must be resolved, in some cases he indicates the time that he has.

The last part of this section of the interview is an invitation to the patient to formulate the most free and fuller the problems that led him to the doctor. The goals of the meeting in the presentation of the doctor and the patient may not coincide at all. If this is so, then it is necessary to discuss the differences and come to a common decision on what goals the meeting has and what issues will be discussed there. It should not, especially in outpatient practice, outline broad and vague goals, it is better to divide the work into several meetings, each of which will be devoted to a specific problem.

Typical medical errors: ignoring the greeting or its non-verbal part, the lack of presentation by the doctor to himself, often the patient is not given the opportunity to formulate the goals of coming to the doctor himself, which is important to do at the beginning of the interview.

Phase I of a clinical interview ("establishing confidence distance") can be defined as an active interview. It is the most important and difficult. The first impression of the patient is able to decide the further course of the

interview, his desire to continue the conversation, to go on disclosing intimate details. Communication of the doctor with the patient begins with situational support. The interviewer takes the thread of conversation into his own hands and, mentally putting himself in the place of the patient who first consulted a doctor, helps to start a conversation. Usually effective to establish a "confidence distance" - psychological comfort is a saying: "I understand how difficult it is to see a doctor. I probably should not say that everything you want to share with me about yourself and your experiences will remain between us. " At further stages, it is desirable to confirm (remind) the patient his confidentiality guarantees, but not directly, but indirectly. For example, questions that are essential for understanding the patient's condition should start with the words: "If it's not a secret, could you tell more about ..." or "Your right not to tell me about ..."; "If you do not want to discuss this topic, we could move on to another one." By such speech methods based on ethical principles, it is possible to quickly and effectively establish the necessary "soul wave" between the doctor and the patient, provided that the communication technique will be a sincere desire to understand the patient's condition, to help him, and not manipulation.

The second stage of the clinical interview is a passive interview. The patient is given time and opportunity to make complaints in the order and with the details and comments that he considers necessary and important.

The third stage of the clinical interview is aimed at identifying the patient's views on the possible and desired results of the interview and therapy. The patient is asked: "From what of the fact that you told me, would you like to get rid of in the first place? How did you imagine before our conversation came to me, and what do you expect from it? How do you think, how could I help you? "The last question is aimed at identifying the patient's preferred method of therapy. After all, it is not uncommon for a patient to refuse treatment after presentation of a complaint to the doctor, referring to the fact that he basically does not take any medications, is skeptical about psychotherapy or does not trust doctors at all. Such situations indicate the desired psychotherapeutic effect from the interview itself, from the opportunity to speak out, to be heard and understood. This is in some cases sufficient for a certain part of those seeking consultation with a doctor or a psychologist. After all, often a person comes to a doctor (especially a psychiatrist) not for a diagnosis, but in order to obtain confirmation of his own convictions about his mental health and poise.

In the middle of the interview you need to ask questions of both types (closed and open), and at the end of it you should ask only closed questions, otherwise the interview will drag on. The most frequent drawback is the use of closed questions at the beginning of the conversation, which leads to a sharp restriction and a decrease in the quality of the information collected by the doctor. Closed questions are not suitable for discussing with the patient

his family, psychological, profound personal or intimate problems. Typical mistakes include frequent use by the doctor of leading questions (especially they are undesirable at the beginning of the interview), as well as posing several questions in a row, without receiving a response to the previous one. The quality of the interview is enhanced if the doctor constantly strives to clarify and clarify the patient's statements, for example, one can not be satisfied with phrases like "I was ill", "I was stressed," "I feel not completely healthy," etc.

IV stage of the clinical interview, the final, newly active role goes to the interviewer. Based on the revealed symptoms, having an idea of the patient about the concept of the disease, knowing what the patient expects from the treatment, the interviewer sends the interview to the channel of the anticipatory training. As a rule, the neurotic fears to think and even discuss with anyone the possible sad outcomes of the conflict situations that existed for him, which led to a doctor and a disease. Anticipatory training is directed, first of all, to thinking out the patient the most negative consequences of his illness and life. [For example, when analyzing a phobic syndrome within a neurotic register, it is advisable to ask questions in the following sequence: "What exactly are you afraid of?" "Something bad is about to happen." - How do you imagine and feel, with whom this bad thing should happen: with you or with your loved ones? - I think, with me. - What exactly do you think it is? "I'm afraid of dying." "What does death mean to you? Whereby is it terrible?" I do not know. - I understand that this is an unpleasant occupation - to think about death, but I ask you, what exactly are you afraid of in death? I will try to help you. For one person, death is nothingness, for another - death itself is terrible, and pains, associated with it, are terrible; for the third, it means that children and relatives will be helpless in the event of death, etc. What is your opinion about this?". Such a reception in the clinical interview serves as a function of more accurate diagnosis of the patient's condition, and has a therapeutic effect.

A doctor using a strategy to increase motivation should at all costs avoid discussions. The dispute gives the patient an opportunity to find the reasons for avoiding the changes and, therefore, can rather slow down the changes than to encourage them. For example, resistance is likely when the doctor tries to put pressure on the patient, urging him to change his behavior before he is ready for it. If the doctor notices that the patient starts to object to behavioral changes, for him it should be a signal to change the strategy.ith patients, relatives of patients and colleagues in various situations.

Closure of the interview. The accuracy of the end of the conversation, the moment for which only the doctor should determine, is important. To properly complete the interview, you must first give the patient several non-verbal signals (for example, change the pose, stop demonstrating active listening, increase the distance, close records), followed by verbal

signals that the interview ends, it may be the words "so", "such Way "," summing up ", etc., and only then finish the interview. To monitor the conversation, it's good to have a watch all the time. Possible shortcomings are a sudden, unexpected ending for the patient, which significantly reduces his satisfaction with the interview, or the end of the interview is prolonged, when the patient intercepts the initiative and continues the conversation that the doctor would like to finish.

Topics of reports, abstracts and creative projects

1. Communicative competence of the doctor and its psychological characteristics forming.
2. The image of the doctor in the eyes of the patient.
3. Professionally significant communicative qualities of the doctor
4. Health of the doctor. The doctor is like a patient.
5. Communication as part of the professional competence of the doctor.
6. Formation of psychological readiness of the doctor to provide medical assistance in extreme conditions.
7. Ethical aspects of the doctor's relationship with colleagues.

6. PUBLIC SPEECH AND PRESENTATIONS

6.1. General terms
6.2. Methods and technics
6.3. General rules of presentation
6.4. Positive communication with audience

6.1. General terms

Public speaking (sometimes termed oratory or oration) is the process or act of performing a speech to a live audience. This type of speech is deliberately structured with three general purposes: **to inform, to persuade, and to entertain.** Closely allied to "**presenting**," although the latter is more often associated with commercial activity, public speaking is commonly understood as formal, face-to-face talking of a single person to a group of listeners.

In public speaking, as in any form of communication, there are five basic elements that are shown through Lasswell's model of communication. In short, the speaker should be answering "who says what in which channel to whom with what effect?" Along with the basic elements of public speaking, the general purpose can range from transmitting information to telling a story to motivating people to act. Public speaking can also be considered a discourse community, where the audience and speaker are working to achieve a certain goal or find a purpose.

Interpersonal communication and public speaking have several common components, including motivational speech, leadership, personal development, business, customer service, large group communication, and mass communication. Public speaking can be a powerful tool to use to persuade, influence, and inform the audience. It also utilizes ethos, or character.

Currently, public speaking for business and commercial events is often done by professionals. These speakers are contracted either independently, through representation by a speakers bureau, or via other means. It is believed that 70% of jobs today involve some form of public speaking.

6.2. Methods and technics

The objectives of a public speaker's presentation can range from telling a simple story to transmitting important information. Professional public speakers often engage in ongoing training and education to refine their craft and improve their skill. This may include seeking guidance from others to improve those skills – such as learning better storytelling techniques or learning how to effectively use humor as a communication tool. They also engage in continuous research in their topic area of focus.

While there are often resources on how to be an effective public speaker readily available for those interested (through internet or library research), professionals in public speaking are not hesitant to share tips and challenges they come across. People tend to listen to their strategies and try to imitate their techniques, however, this is not effective as everyone is different and handles situations differently. According to professionals, great public speaking comes from the heart, by persuading the audience into believing what one is saying.

In brief, some of the tips included mention: how to engage the audience, how to prepare for a long speech, important things to remember when speaking, things to avoid, and the importance of a backup plan.

One very important aspect of giving a speech is credibility or ethos. This is necessary to establish with an audience so that it is evident that one is reliable and informed when it comes to the subject at hand. A good way to establish credibility is with a credibility statement. This will show listeners that the speaker is someone worth listening to about the given topic. This statement can include evidence of extensive research and study, passion for a particular issue, or personal experience. There are three important characteristics that will help one establish good ethos: good sense, good will, and good moral character. Establishing these characteristics with the audience will show that the speaker is presenting information that is trustworthy and said with good intentions.

Public speaking training centers promote the idea of adapting certain life-stances for becoming a growing orator. These life-stances are called the 12 "E" life stances

Training effective public speaking can be developed by special public speaking exercises. These include:

- Oratory;
- The use of gestures;
- Control of the voice (inflection);
- Vocabulary, register, word choice;
- Speaking notes;
- Using humor;
- Developing a relationship with the audience.

Effective leadership almost always requires the skill of good public speaking, and this can often make up for a lack of other skills. Leaders from Adolf Hitler to Martin Luther King, Jr. were effective orators who used oratory to have a significant impact on society. The speeches of politicians are often widely analyzed by both theirs fans and detractors.

The common fear of public speaking is called glossophobia (or, informally, "stage fright"). Many careers require some ability in public speaking, for example presenting information to clients or colleagues.

6.3. General rules of presentation

Public speaking and oration are sometimes considered some of the most importantly valued skills that an individual can possess. This skill can be used for almost anything. Most great speakers have a natural ability to display the skills and effectiveness that can help to engage and move an audience for whatever purpose. Language and rhetoric use are among two of the most important aspects of public speaking and interpersonal communication. Having knowledge and understanding of the use and purpose of communication can help to make a more effective speaker communicate their message in an effectual way.

1. Volume.

This is not a question of treating the voice like the volume control on the TV remote. Some people have naturally soft voices and physically cannot bellow. Additionally, if the voice is raised too much, tonal quality is lost. Instead of raising the voice it should be '*projected out*'. Support the voice with lots of breath - the further you want to project the voice out, the more breath you need.

When talking to a group or meeting, it is important to never aim your talk to the front row or just to the people nearest you, but to consciously project what you have to say to those furthest away. By developing a *strong voice,* as opposed to a loud voice, you will be seen as someone positive.

2. Clarity.

Some people tend to speak through clenched teeth and with little movement of their lips. It is this inability to open mouths and failure to make speech sounds with precision that is the root cause of inaudibility. The sound is locked into the mouth and not let out. To have good articulation it is important to unclench the jaw, open the mouth and give full benefit to each sound you make, paying particular attention to the ends of words. This will also help your audience as a certain amount of lip-reading will be possible.

3. Variety.

To make speech effective and interesting, certain techniques can be applied. However, it is important not to sound false or as if you are giving a performance. Whilst words convey meaning, how they are said reflects feelings and emotions. Vocal variety can be achieved by variations in:

- *Pace:* This is the speed at which you talk. If speech is too fast then the listeners will not have time to assimilate what is being said. Nevertheless, it is a good idea to vary the pace - quickening up at times and then slowing down – this will help to maintain interest.
- *Volume:* By raising or lowering volume occasionally, you can create emphasis. If you drop your voice to almost a whisper (as long as it is projected) for a sentence or two, it will make your audience suddenly alert, be careful not to overuse this technique.
- *Pitch - Inflection - Emphasis:* When speaking in public, try to convey the information with as much vocal energy and enthusiasm as possible. This does not mean your voice has to swoop and dive all over the place in an uncontrolled manner. Try to make the talk interesting and remember that when you are nervous or even excited, vocal chords tense and shorten causing the voice to get higher. Emphasize certain words and phrases within the talk to convey their importance and help to add variety.
- *Pause:* Pauses are powerful. They can be used for effect to highlight the preceding statement or to gain attention before an important message. Pauses mean silence for a few seconds. Listeners interpret meaning during pauses so have the courage to stay silent for up to five seconds – dramatic pauses like this convey authority and confidence.

6.4. Positive communication with audience

Below are ten useful pointers to put into practice to ensure you speak with confidence, clarity and impact the next time you present.

1. DEALING WITH NERVES

Nerves are good. Without nerves, you have no chance of performing to your potential. Yet as we all know, uncontrolled nerves can make the difference between polished fluency and scratchy inadequacy. The key lies in control. Nerves need to be replaced by confidence – this can mean visualizing your goal. Motivate yourself with the image of a confident and

competent performer. "It’s all in the mind" is truer than we imagine. Persuade yourself that you are a good speaker and your presentation skills will improve.

2. PUT YOURSELF IN THE AUDIENCE'S SHOES

It is important to resist the temptation to convey all you know about a subject. Enhance your presentation skills by approaching your subject from your audience's point of view and what they want to hear. Refer to their concerns and give examples pertinent to their lives. Don't run through a series of features - explain the benefits which they can derive from a course of action. Talk in the audience's language, avoiding the barriers created by jargon.

3. KEEP IT SIMPLE

The purpose of a presentation is to put across key messages, convince your audience of your competence and generate enthusiasm to take the next step. Garnish your presentation with examples, anecdotes, repetition and references to the audience's own experiences so that facts have sufficient time and supporting evidence to be remembered.

4. SIGNPOSTS

You know where you are in your presentation. But unless you clarify your position and progress to your audience, they will have no idea. You will lose them. Competent presenters will always explain what they are going to cover – and how. Then they cover it, reminding you regularly of where they are in the narrative. If you lose the thread, they weave you back into the story at regular points. And finally, they reiterate what has been said, so that key messages reverberate as you leave.

5. WORDS THAT WIN SUPPORT

Persuasion is the object of every presentation. Your choice of words is crucial in achieving this. One of the most powerful words at your disposal is 'you'. It is astonishing the difference that arises between a passive statement of fact and its active personalization. Peppering your presentation with 'you' and 'we' is inclusive and empathetic.

6. VISUAL AIDS THAT ADD VALUE

Visual aids should do just that: help the audience visually. They are there to reinforce your message, provide cues for your presentation and in some instances make points with greater impact that words could achieve. What they must not do is take over.

7. VISUAL IMPACT

You can enhance your presentation skills by improving some of the fundamentals of presenting - good eye contact, natural hand gestures, a relaxed stance and an open manner. By doing this you will stand a much better chance of impressing and grabbing the attention of your audience.

8. VOCAL IMPRESSION

Making the best use of your voice is as important as visual impact. In a good speaker you will hear modulation and control. They use pauses effectively as a means to bring the audience's attention level back. The voice is a flexible and powerful tool. Try to vary your tone as often as possible to add emphasis to what you say.

9. HOW TO ANSWER QUESTIONS

Perhaps second only to the fear of drying up in a presentation is the fear of questions. Yet there are no impossible questions. If you know your subject, you will be able to respond to all sensible queries.

If you don't know the answer, admit it candidly and calmly. Never guess, never waffle.

10. PRACTISE - THEN PRACTISE MORE

The more time you spend on preparation, practice and developing your presentation skills, the more likely you are to give visual impact and vocal impression their due. You can never prepare too much and the effects of doing too little will always be evident to your audience. The more effort you put into the preparation stage the more confident you will be in the delivery.

References:

1. German, Kathleen M. (2010). Principles of Public Speaking. Boston: Allyn&Bacon. p. 6
2. Borchers, Timothy A. (2006). Rhetorical theory : an introductio. Belmont, CA: Thomson/Wadsworth
3. Ryan, David (2007). The Speaking/Writing Connection. Berkeley, CA: ParthenonWestBooks
4. Zakahi, Walter (1988). "Communication Education". West Virginia: Speech Communication Press

Topics of reports, abstracts and creative projects

1. Everyday conversation and public speaking: similarities and differences.
2. Personality of orator as main factor of effective presentation.
3. Appearance and behavior of orator as instruments of public speaking.
4. How to make good impression to the audience during public speech.
5. Importance of eye contact with audience.
6. How to attract and hold attention of audience.
7. Reliability of orator as indicator of his mastery.
8. Types of orators.
9. Role of first impression in assessment of orator skills.

10. Main rules of presentation.

7. SCRIPTS AND TECHNICS OF COMMUNICATIONS

7.1. Algorithms of communications, the technique of scripts.

7.2. Modeling of communicative scenarios: the scenario of persuasion, the "language of benefits for the patient and the doctor", mirroring, etc.

7.3. Communicative techniques and a set of key phrases for working with "objection."

7.1. Algorithms of communications, the technique of scripts

The script is a high-level scripting language - brief descriptions of the actions that determine the role of the doctor, his properties, characteristics, behavior and interaction with patients, relatives of patients and colleagues in various situations.

The use of communicative techniques ("scripts") allows to improve the quality of working out the patient's objections and correctly neutralize its negative, which directly affects the image of both the doctor himself and the medical organization where he works. The most highly evaluated characteristics of a doctor are: humanity; competence / correctness; Involving patients in decision-making; Time for care and treatment.

Patients are looking for a doctor who listens and does not rush them; Give them information and an opportunity to participate. Patient satisfaction is particularly enhanced with a patient-centered approach in consultation. To implement these characteristics, algorithms of communication with patients, voice modules help. Scripts work best in frequently repeated situations.

The external world and the subconscious interact with consciousness through three modalities - the basic systems of images, sensations and representations: visual (visual), auditory (auditory), kinesthetic (sensual), one of which is leading in the processing of information. This modality is called the leading representative system of man. In accordance with the dominant modality of people are divided into three groups:

- visuals (perceiving and processing information in the form of images);
- audials (perceiving and processing information in the form of sounds and words);
- kinestetiks (perceiving and processing information in the form of sensations).

The main communicative techniques in the practice of a medical professional are: reflexive and empathic listening, feedback, utterance. Skilful use of communicative techniques, means, communicative distance

and the angle of communication makes it possible to achieve an establishment of contact.

Reflexive listening is the process of deciphering the meaning of messages and assumes objective feedback. It is used to confirm the understanding of the speaker's message. Reflexive listening increases the accuracy of understanding, provides favorable conditions for conversation, helps to clarify the meaning of polysemantic words, in other words, helps to "decode" a person, how to try the water that we are going to enter.

Situations in which an effectively reflective listening: 1) when the interlocutor does not want to speak or is small; 2) when the speaker seeks to get a lot of support, including, emotional; 3) when a person needs help in solving certain problems; 4) if the conversation of one contradicts the interests of the other.

Empathic listening differs from reflective, primarily installation. The goal of a reflexive hearing is to understand and convey the speaker's feelings as accurately as possible and empathic listening to catch the emotional coloring of ideas and their meaning for another person, to penetrate into the system of his internal values and to understand what is truly meant for another person and what feelings he has in doing so Tests. This is a rather intimate kind of communication with high emotional stress. Empathic listening provides a better understanding of other people, helps to neutralize the general propensity to judge, helps to avoid the polarization of the type of "I-they", which prevents effective communication. It allows you to experience the same feelings that the interlocutor experiences, to understand the emotional state of the interlocutor and to share it. Empathy - literally means "sympathize," that is, "I feel the same as you". Empathic listening creates a favorable climate for the open expression of others with their own thoughts and feelings. The methods of reflexive and empathetic listening let you know what the partner is really saying, to understand the true meaning of what is behind his words.

Rules of empathic hearing.

1. It is necessary to be attuned to the hearing: temporarily forget about your problems, get rid of your own experiences and try to move away from ready attitudes and prejudices about the communication partner.

2. In his reaction to the patient's words, it is necessary to reflect the experience, the emotions behind his statement, to demonstrate to the interlocutor that his feeling is understood correctly.

3. It is necessary to pause. In the course of a conversation, the communication partner often needs to be quiet, think over what he has heard or think over his answer. It is not necessary at this time to express any additional considerations, clarifications, clarifications or comments, a pause is necessary for the interlocutor to understand his experience.

4. In those cases when a person is excited, when the conversation develops in such a way that he continues to talk uncontrollably, to tell, and the conversation is already of a confidential nature, it is advisable to switch from an empathic hearing to a non-reflexive one.

5. The method of empathic hearing makes sense only when a person wants to share some experiences.

Empathy can be expressed verbally or nonverbally. Verbally:

− "I'm sorry";
− "You must be very difficult to cope with ...";
− "You seem (sad, angry, depressed) today";
− "This is not an easy time for you";
− "We will work together to get through this";
− "Please call me at any time" (if you said this, then rest assured that you will be available).

Nonverbal:

- Use a sad or sympathetic intonation;
- Express facial expressions of concern;
- Touch the patient's hand.

To convince a patient to follow a doctor's recommendation, it is necessary to recognize the patient's social personality type. There are 4 social types of the patient: analyst; friendly; directive; expressive.

1. The most correct strategy in dealing with a friendly patient is to win trust, attention to his problem. Make it clear that you hear it, you know. Demonstrate a warm interpersonal relationship, avoiding a low-emotional and authoritarian manner of prescribing therapy. The position of teamwork is important. When talking, try to refer to your positive personal experience and (or) the experience of your colleagues. Discuss the concerns about the upcoming therapy. Treatment should include commitment: "Do not worry, I will monitor your health."

2. The most correct strategy in dealing with an expressive patient is to avoid a low-emotional and authoritarian manner of prescribing therapy; This category of patients appreciates an innovative and creative approach to therapy in the physician; Sentences must be brightly emotionally colored; Try to avoid long logical explanations; Recommend simple treatment regimens; It is advisable to use jokes or some funny situations as an example.

3. The most correct strategy in communicating with the prescribing patient is competence and confidence. Algorithm of doctor's communication and directive patient: brevity and brevity; Avoid unnecessary emotions and empty talk about anything; Arguments are compelling and short; Scheme of taking the drug is personal and exclusive ("Only for you ...", "Exceptionally in your case ...", etc.); recommendations contain specific benefits for the patient, the specific outcome and effect of the treatment; the manner of appointment is not emotional, "authoritarian".

4. The patient-analyst is important details, facts, logic in the prescribed treatment with mandatory evidence. Key motives in choosing a therapeutic tactic: evidence, effectiveness.

A doctor with good communication skills gets a great job satisfaction, works less with stress, more accurately identifies the patient's problems, and his patients are easier to adjust psychologically, they are more satisfied with the help they provide.

For good information gathering, the doctor should only ask open questions to the patient. Examples of open questions: "Tell me about your health," "I would like to learn more about the health of your close relatives," "What do you think about the causes of your illness?", etc. Closed questions are valuable for determining goals, for determining certain events, for having specific symptoms or signs of subjective symptoms, for obtaining specific information and suggesting answers "yes" or "no": "Do you have pain in your heart?", "Has your Weight during the illness? "," When did fatigue begin? "," Was there a weakness in your left arm? "" Have you thought about suicide? ", etc.

The advantage of open questions is that they allow you to get much more information about the patient, the symptoms, the patient's attitude to the disease, his views, fears, etc., but the answers to them require much more time than answers to closed questions. If you do not have enough time, the questions should be more specific.

To identify feelings, thoughts, functions and expectations, to establish a personal aspect of the problem, begin by inviting the patient to tell the story of the problem from the time it first began to this day. For example: "Tell me everything from the beginning ..." Wait for the patient to complete one complaint before asking another question. Determine with the patient what is his greatest concern and agree to post nonessential questions to another visit. Ask questions that help determine how the problem affects the daily functioning of the patient. Ask the patient what, in his opinion, caused this problem: "What do you think caused this?" Determine the patient's expectations about what kind of help he wants to receive. Because patients come with their own expectations about a possible resolution of problems, your recommendations may not be accepted, because the patient does not agree with them or is not interested in them: "What do you want me to do to help you?".

Summarize what you understand by the key problems of the patient. Encourage the patient to supplement the information already reported to them and / or correct what you said.

Express sensitivity to the disclosure and discussion of complex emotional problems. Ask questions about the feelings of patients, for example:

"How do you feel about this?";

"What is the biggest concern for you in all this?"

Be neutral. Staying neutral is particularly difficult in cases of marked personal identity of the patient. The doctor's work requires a wide repertoire of communicative skills and tolerance. Some patients are annoyed, but one should never forget that for this there can be quite understandable medical or situational reasons.

Try to assess the problems affecting the patient? "Tell me, how does this affect you?" Or: "This can cause you problems in your daily life: could you tell me about these problems?"

We must try to see the problems from the point of view of the patient. What is usual for you, can be very important for the patient. Recognize this - "I agree that this is a big concern."

Do not dominate. In particular, when working with patients in bed, it helps to go down to the level of the patient. Seeing someone towering above themselves, patients may experience special vulnerability and discomfort. It is noticed that male doctors ask men "What's the problem?", but women should ask "What seems to be a problem for you?".

Do not be ignorant. It's about the problem of destroying the patient's trust with your ignorance. Sometimes it is quite appropriate to say bluntly: "There are people who know more about this than me," but to soften "I will consult with ...".

Communicate slowly. Interrupt with caution. The interrupt technique is key, when the interviewer needs immediate explanations of the decisive moments as the story unfolds.

Encourage the patient from time to time. Minor comments such as "Yes", "True" or nodding can convince the patient that you are listening to him and that your attention is focused on him.

Strengthen positivity. Not: "The harm of smoking is ...", but better: "The advantages of quitting are ..." Emphasize positivity, even when there are negative messages. "Yes, this is all bad news. The good news is that ... "

Expanding issues can be useful for identifying certain points:

- "Is there anything else you would like to say to me?"
- "Is there anything else you should tell me?"
- "What else should I know?"

A frequent mistake of the doctor in the process of communication is "erroneous opinion". Many errors in communication come from the assumption that the other person correctly understands what you are saying. In some cases, factors such as emotions, differences in cultural environment and education can contribute to distortion of information from the "transferring" to the "receiving". One of the tools that the doctor can use to determine whether the patient has correctly received the message is a clarification. For example: "I heard, you said ... Is it so?", "It seemed to me

that it was said ... Did I understand you correctly?", "If I understood you correctly, ... Do you agree?".

The patient's confidence in his doctor reduces such statements as:

- "Let's see what will happen ...";
- "I don’t know";
- "We need to consult a nurse";
- "I have not had to face this before";
- "I'm not sure about this";
- "I need time to learn more";
- "I must use books to find out about the state";
- "I have to use a computer to find out about the state".

Confidence causes a calm, harmonious and confident doctor. A sense of responsibility, the ability to control oneself is always valued by patients and colleagues. But not arrogance, vanity, greed and envy. Authority is the result of therapeutic activity + the opinion of others. Good, companionable relationships in the team are extremely necessary. In a medical team, each employee has his own place, his duties, his own range of activities. Modern medicine, being extremely developed and narrowly specialized, increasingly requires teamwork. This, in turn, requires clarity of interaction and relationships in the team. Now there is no specialist in any field of medicine that understands "in everything". The doctor's relationship with colleagues and the entire medical team requires him to have great knowledge and training, a culture of behavior and endurance, upbringing and self-education. Important qualities of each doctor should be goodwill towards colleagues, accessibility for contacts, readiness to consult other doctors and, on the contrary, come to the aid of the word and deed to their colleagues.

7.2. Modeling of communicative scenarios: the scenario of persuasion, the "language of benefits for the patient and the doctor", mirroring, etc.

Situation: The patient does not clearly worry about anything, and you need to convince him to undergo the examination (and he really needs it), or to have surgery (if it is a matter of precancerous conditions), but you do not get more than 25% of the cases. So, we need to model a new communicative script-scenario of persuasion, constructive manipulation of the patient in his own interests.

There is Murphy's Law: "If any trouble theoretically has a chance to happen, it will necessarily happen." If we prepare a separate script for each situation, then we seem to statistically reduce the likelihood that Murphy's Law will work.

There is an important rule - if you improve a particular skill, then improve your other skills and indicators. For example, if you improve the skill of psychography and reading the patient's gestures, then you begin to be

more attentive to it, better understand its needs, it is easier to adapt to it. That is, become more patient-oriented.

"Mirroring" the patient to 50% increases the likelihood of maximum agreement with him. Applying this technique, we seem to copy our patient: take the same pose, talk at the same pace, use the same gestures, etc.

One of the most important skills in communicating with patients is to talk with patients in the "benefit language". This skill is also known as FAB (feature-advantage-benefit - characteristic-benefits-benefits). The essence of the skill is to tempt the patient not with properties, not with the description of the details of the treatment, but with the benefits of one or another therapy scheme. The "benefit language" is very effective if the doctor uses it correctly. Unfortunately, doctors practically do not possess this skill, and if they do, they do not always use it to a sufficient degree.

This skill should be used in any communications and adapted strictly to the level of perception of the patient. For example, such a small factor as the small size of a tube of ointment can be perceived as positive (a convenient size, you can take it with you, it will not take much space in your purse), and negatively (it's easy to lose, not enough for a long time). Hence the practical conclusion is that it is always necessary to translate the characteristics of medical services through their advantages into the language of benefits for the patient. Modern ultrasound equipment is also perceived as positive (guaranteeing the correct diagnosis) and negatively (irradiation of the body). Consider the case of hypertensive disease. Using the "benefit language", it is correct to say that a certain antihypertensive drug has a long half-life, which makes it possible to take it only once a day and be calm for the level of arterial pressure within 24 hours. However, in a conversation with an ordinary patient, such a characteristic of the drug , As the half-life, it is necessary to replace with another formulation: "Enough for a long time remains in the body."

7.3. Communicative techniques and a set of key phrases for working with "objection"

Most often, "objections" arise because of any communicative errors. Objections in patients arise when the doctor did not fully clarify the situation and did not substantiate his vision of the treatment-diagnostic process from the point of view of the patient. There is nothing to worry about, this is a normal working situation. The patient has the right to object. There are four basic prerequisites for objections.

1. Natural resistance to everything new and different. For example, you explain to the patient that he needs to change the habitual way of life and that if he continues to drink, smoke, then everything for him may end badly. People do not like to change, it's much easier for them to argue, to put your

claims into question: "What do these doctors know, they always intimidate ...".

2. Sensation of pressure and intrusion into the patient's private space. Often in the process of collecting an anamnesis, one has to dig up to various intimate nuances, and this is not what everyone likes.

3. During your argument, the patient's medical knowledge, as well as the absence of such questions, raise doubts, and the patient has the right to state them (he read something on the Internet, had some ideas about how this or that problem is treated). There are meticulous "patient-analysts" who have chronic diseases, for example, diabetes, and they really know a lot about their illness, turn to different doctors, and therefore are inclined to examine the doctor.

4. The stereotype of free medicine is a direct reason for objections. Often treatment and some diagnostic procedures have to be paid, and many patients sincerely do not want or can not afford it.

Main sources of objections:

1. The patient wants to get additional information and objects simply: "You know, I read the instruction, there are so many side effects", "Doctor, well, why immediately antibiotics", etc.

2. The patient wants to compare the quality level ("I heard that imported medicines are no worse than domestic medicines and are cheaper").

3. Objection as a polite refusal on your offer. This is the most unpleasant type of objection, very dangerous phrases like: "I'll think / will keep in mind." For example, you offer surgery, the need for which is beyond doubt, and the patient says: "I need to think ...". Almost always this is a hidden objection. After you hear this phrase, you need a specific question script aimed at "revealing" the patient.

Do not do it:

− to question the validity of the patient's objections;
− argue with the patient;
− interrupt the patient.

How to overcome objections? An effective model of ISIDA (truth, agreement, union and, another point of view, argumentation) is effective.

True. First you need to find out the true objection. Often doctors begin to work with an objection, in fact, not understanding what it is. For example: "Doctor, your scheme does not work, I do not get better." Why did the patient decide how he measures the effectiveness of therapy and what results does he expect? You can not begin work with an objection without establishing the truth.

Consent. Hearing "yes", the person unconsciously relaxes. You can agree with anything - with a part of the phrase, with an emotional tone, with the very ability to object. For example: "Yes, I sometimes hear it", "Yes, sometimes it happens", "Yes, some think so."

Stubborn "but" we always replace the kind and friendly "and". In a conversation, this is imperceptible, but we are moving away from the opposing and unloved "but". Effectively use such phrases as "and at the same time", "and judge for yourself", "and at the same time," and "we also understand with you." These phrases transfer the doctor and the patient to one side.

Another opinion. Then another is expressed - an alternative - opinion or point of view.

Argumentation. Here the doctor says that this other opinion has a real argument. Good links to statistics, research, to something important, which has an evidentiary basis.

For example, objections in the style of "I'll think ...". As already mentioned, patients often do not express objections directly, hiding them behind vague promises to think. An important practical rule: a doctor should not "let go" the patient after the phrase "need to think", because this trick of the patient is a missed opportunity for the doctor. If the patient says "I'll think about", it often means that he has already made a decision not in your favor. And that's why a "golden question" is needed after this phrase. Here are its modifications:

• *"It seems to me that you have doubts about the proposed treatment. Perhaps I could not tell you something? "*

• *"It seems that I could not bring all the benefits of the proposed treatment scheme?"*

In this case, the main thing is the wording. For example, you can not say this: "It seems to me that you did not fully understand me." All responsibility in the matter must be taken over: "I failed ...", "I could not provide you the most complete information...".

Topics of reports, abstracts and creative projects

1. Effective communication of the doctor with patients and their relatives.
2. Scripts and techniques of communication when working with deviant patients.
3. The most common mistakes of a doctor in a conversation with a patient.
4. The technique of active listening.
5. The technique of "overcoming objections."
6. Scenarios of the doctor's work with the patient in various situations.

8. COMMUNICATIVE BARRIERS IN THE COURSE OF COMMUNICATION

8.1. Emergence of communicative barriers in the course of communication of the doctor with patients, relatives of patients and colleagues in various situations

8.2. Communicative barriers of social and psychological nature: phonetic, semantic, stylistic, logical, welfare, low level of knowledge, interest and responsibility for own health at the population.

8.3. Restrictions of process of communication in health sector.

8.1. Emergence of communicative barriers in the course of communication of the doctor with patients, relatives of patients and colleagues in various situations

Communication barriers − the hindrances interfering the implementation of contacts and interaction between a communicator and the recipient. They interfere with adequate acceptance, understanding and assimilation of messages in the course of implementation of communicative communications.

The main obstacles in a way of full communication "the doctor - the patient":

1) Use in a conversation simplified the technician or schemes. For example, the doctor acts as "trustee", and the patient as the contractor or the pupil. In these cases from lips of the doctor such phrases "most often sound try to calm down"; "get it together"; everything will be OK; "try to distract". In such situations the doctor just tries to leave from a difficult situation and restacks responsibility for this condition on the patient, forgetting that communication in itself and is medical process.

2) Personality characteristics of doctors and patients are various. But understanding of personal features of the patient allows the doctor to interact effectively with it.

3) Lack of knowledge and skills of use of various forms and methods of communications. Wrong choice of language means. Persons and their characteristics usually change a little during life, but use even simple the technician of communications can help communication. Therefore prior experience of the doctor, knowledge of various forms and methods of communications is very important.

4) Distinction in perception is a widespread barrier on the way of exchange of information. Patients usually want to know the diagnosis, but can underestimate its value and can reluctantly ask about it. Their perception of information differs from what the doctor told and wanted to tell. Some patients can not wish to know "truth". Denial is sometimes the effective mechanism of a adaptation. Ignorance, especially concerning things which

can't be changed allows people to continue to function. Depending on a situation, sometimes pertinently to help the patient to make the decision at its speed or to tell "We, perhaps, will discuss it later" and to leave it to the patient for adoption of own decision.

5) Insufficient understanding or assessment of need of risk. Much of what is advised or done by the doctor depends on risk benefit assessment in comparison with other, less risk actions. Often, the best that doctors can make, − it to measure risk and to give it a quantitative assessment. Patients can be helped, having told what could be made, being in similar circumstances, you, but to emphasize that not you, but they shall make the decision. This approach "if I was in your situation" was especially useful in work with relatives who, perhaps, should make decisions on behalf of the aged parents.

Can be the reasons of bad communication:

− - stereotypes − the simplified opinions concerning individuals or a situation, as a result there is no objective analysis and understanding of people, situations, problems;

− "prejudiced representations" − tendency to reject everything that contradicts own views that is new, it is unusual ("We believe what we want to trust to").

− bad human relations, as if the relation of the person hostile, then it is difficult to convince him of justice of your look;

− lack of attention and interest of the interlocutor, and interest arises when the person realizes value of information for himself;

− neglect the facts, i.e. a habit to do conclusions in the absence of enough proofs;

− mistakes in creation of statements: wrong choice of words, complexity of the message, weak persuasiveness, illogicality, etc.;

− incorrect choice of strategy and tactics of communication;

− nonverbal signals can complicate communication if they conflict to word meaning;

− bad feedback and inability prevent to listen to effective exchange of information.

Application more the personal aligned approach, the aspiration to look at a situation from the point of view of the patient will make the patient more relaxed, more free and will lead to more effective consultation and diagnostics. It will also help to save time.

Note that communication problems in health service can arise as result of the fact that workers of health service are more focused on diseases and their treatment, than in public and their problems of health. The patient-aligned approaches in assistance are protected by consumers and clinical physicians more and more and are included in training of workers of health service.

Clinical example: The doctor wants to hospitalize the elderly woman with abdominal pain for a series of researches, but it resists hospitalization. The following reasons of such behavior are possible:

− she is afraid of the fact that it is seriously sick;

− she doesn't want to leave a cat one in the house;

− it − the vegetarian is also afraid that she won't be able to eat hospital food;

− she doesn't want that someone knew about what she snores;

− she isn't able to afford a new nightgown.

It is opened injuring for the patient there can be expressions: "it is necessary to go urgently to hospital", "well, and we sweat over your operation, smart guy", "as you can fall asleep if you have pressure 200/100", "such young, and such patient", "your heart is more senior than you"; on massage − "kick the bucket", "you have no veins", "your situation is very serious", "your disease is almost incurable presently", "you long should be ill", "vessels are struck with atherosclerosis, the aorta is expanded, lived the grandmother and will be enough", etc.

Emergence of communicative barriers with colleagues.

Quite often there are friction between "experienced" and "young" doctors. Barrier "authority". Having parted all people on authoritative and unauthoritative, the person trusts only the first and refuses trust to others. Thus, the trust and mistrust are as if personified and depend not on features of the transmitted data, and on the one who speaks. For example, experienced experts poorly listen to councils of young people.

"Competition" between doctors of one generation in knowledge, professionalism, a gain of the authority at patients often accepts unhealthy character, leading to friction, spores, the conflicts. Tension of the relations between members of collective leads to emergence of concern at patients, even to deterioration in their state. Goodwill has to be combined with justice, the maximum insistence and severity according to fault (if it is proved) the colleague. The scornful or haughty attitude towards colleagues, ambition, complacency of the doctor is inadmissible. Exclusively harmful trait of character of the doctor is envy.

8.2. Communicative barriers of social and psychological nature: phonetic, semantic, stylistic, logical, welfare, low level of knowledge, interest and responsibility for own health at the population

Allocate communicative barriers of social and psychological nature. On the one hand, such barriers can arise because there is no understanding and) communication situations, caused by not just various language which participants of communicative process, but b speak) the distinctions of deeper plan existing between partners. It can be social, political, religious, professional distinctions which not only generate different interpretation of

the same concepts used in the course of communication, but also in general various attitude, outlook, outlook. Such barriers are generated by the objective social reasons, as belonging of partners in communication to various social groups, and in case of their manifestation the communication inclusiveness in broader system of the public relations especially distinctly acts. Communication in this case shows that characteristic that it is only the party of communication. It is natural that process of communication is performed also in the presence of these barriers: even military opponents conduct negotiations. But the situation of the communicative act becomes complicated thanks to their availability.

On the other hand, barriers in case of communication can have also more net expressed psychological character. They can arise or c) owing to the specific psychological features communicating (for example, excessive shyness of one of them, reserve of another, presence at someone the line which received the name "uncommunicativeness"), or d) owing to developed between communicating special type of psychological relations: hostility on the relation to each other, mistrust, etc.

Communicative barriers:

1. Phonetic misunderstanding – different languages.
2. A semantic barrier – distinction in system of values of participants of communication.
3. Stylistic – discrepancy of style of the speech of a communicator and situation of communication.
4. A logical barrier – the logic of a reasoning of a communicator or is too difficult or it seems not true.
5. A welfare barrier – the social, political, spiritual distinctions determining degree of the authority of a communicator.

1. The phonetic barrier can arise when the doctor and the patient speak quickly and inexpressively or different languages and dialects, have defects of the speech and diction. Different perception of information at different people depends on nature of thinking, a focus of interest, an emotional condition, the education level, life experience, a sex, age.

2. The semantic (semantic) barrier is connected with a problem of a slang peculiar to people of certain age groups, professions or a social position (for example, language of teenagers, addicts, seamen, hackers, inhabitants of remote areas, etc.). Semantics studies the method of use of words and values expressed in words. As words in the form of symbols can have different value for different people, their interpretation by the receiver of information cannot match the sense pledged by the sender. Often same words can have different value and their use can cause incorrect understanding. Removal of such barrier − an urgent problem for representatives of a medical profession as success of therapeutic contact depends on its overcoming. Therefore the doctor shall have skills of assimilation of someone else's semantic systems.

Especially important it for the doctor of emergency medical service. Specifics of work in service of the emergency help oblige the doctor to own fully all acceptances of psychology of communication and to be able to be guided and come quickly into contact with patients, and also with relatives, eyewitnesses of incidents, employees of militia, etc. In emergency situations correctly collected anamnesis, fast contact with the patient often costs to the person life. On the other hand, happens that the medic himself provokes emergence of a semantic barrier at the patient, without need using professional terms.

3. Emergence of a stylistic barrier is possible in case of discrepancy of the speech of the doctor of a situation of communication, for example, in case of his familiar behavior when it all patients is more senior than a certain age "granny" and "old man" calls, doesn't consider psychological features of people and their psychological state (change of consciousness owing to a disease or acceptance of medicines).

4. When the doctor has psychopreventive talks with patients before various interventions, trains them in skills of acceptance of medicines, use of the equipment, acquaints with various techniques of a healthy lifestyle, there can be a barrier of logical misunderstanding, i.e. the logic of reasoning of the doctor can be or is too difficult for the patient, or to seem to it incorrect or unconvincing. The logic of proofs of the patient can also be wrong from the point of view of the doctor.

5. As an origin of welfare barriers perception of the patient as persons of a certain profession, a nationality, a sex, age, the social status can act. The doctor shall be ready also that his authority is insufficient for a certain part of patients; especially it is urgent for young doctors.

6. In the course of communication of the doctor and the patient there can be also barriers of the relations. It is about negative emotions which are caused by the person (and, it is often difficult to realize the reason of it), about forming to it the negative relation which extends and on information transferred to them ("Why you listen to this Maria Ivanovna? Unless she can tell something acceptable?").

Considering essence of a psychological barrier, it is necessary to notice that any of them − it, first of all protection which is built by the patient on the way of information offered him. For example, we will imagine the heavy smoker who has felt badly and addressed for council the friend, the professional physician. The friend, having estimated state of his health, declares need to leave off smoking, adducing the following argument: "You have rigid a breath, and heart plays pranks". If the person doesn't want to spend efforts and to give up long term habit how he can be protected from so unpleasant and injuring information? There are several psychological barriers which are used for this purpose. The first way − distortion of such information, special attention to all facts contradicting it: "Today I feel much

better, heart was quiet − this temporary phenomenon" or: "In this note it is said that smoking helps to cope with a stress". Second way − decrease in authoritativeness of a source of information: "Of course, he is a doctor, but there are already a lot of years as goes in for gastroenterology. Much he understands in cardiac diseases!". At last, the third opportunity − protection through misunderstanding; "He would know that such really bad breath! Here at my neighbor, for example! And nothing, smokes".

Nonverbal barriers. Nonverbal symbols can interfere with the correct information transfer, the perception process, for example a monotonous low voice, an inadequate mimicry, excessive gesticulation.

Bad feedback. Lack of feedback concerning the sent message can serve as a barrier in communication. Feedback is important as it gives the chance to establish whether your message accepted by the recipient is valid is interpreted in that sense in what you have transferred him. There is a set of the reasons of the wrong understanding of the message.

Inability to listen. The nature has given to the person two ears and only one language, having thinly hinted that it is better to listen more, than to speak. The people who aren't listening obtain less information for adoption of the weighed decisions.

Bad hearing is not lack of hearing, but such hearing at which speaking certain hindrances are created, process of speaking is at a loss. Allocate a number of reciprocal judgments listening which create difficulties speaking ("communication barriers"):

-order, specifying, team: "Repeat once again!", "Speak more slowly", "Don't speak with me in this way!";

- prevention, threat, promise: "Once again will repeat – and with you everything is over", "Calm down, and I willingly will listen to you", "You will regret if you make it";
- lecture, specifying on feasibility: "You should go the first", "It is wrong", "You shouldn't act this way";
- recommendation, recommendation or decision: "Why not to tell you so?", "I would suggest you to appeal against it!", "Try to act this way";
- morals, logical argumentation: "Look at it differently", "It is entrusted to you, means − it is your problem", "At your age I also had no it";
- condemnation, criticism, disagreement, accusation: "What you made is silly", "You on a right way now", "I can't argue with you any more", "I warned you that it happens";
- praise, consent: "I consider that you are right", "It was remarkable", "We are proud of you";
- abuse, unreasonable generalization, humiliation: "Well, well, mister Expert!", "All women are identical";

- interpretation, analysis, diagnostics: "You really don't trust in it, isn't it?", "You tell it only to upset me", "It is clear to me now why you made it";
- quieting, sympathy, consolation, support: "Next time you will better feel", "I had such feeling too", "All make mistakes", "All of us support you";
- examination, interrogation: "Who wised up you?", "What you will make next time?";
- withdrawal from a problem, derivation of attention, a joke: "Why don't you dismiss it?", "Let's talk about something another", "And that if every time when something is impossible, to stop being engaged in it?".

These types of reactions of listening make destructive impact on communication. They, as a rule, disturb the interlocutor and disturb his thoughts. Most of them means desire to change the train of thought of the interlocutor or to change him. These hindrances steadily force the interlocutor to resort to protection, causing irritation and indignation. As a result he begins to argue the point of view or aims to hide the thoughts and feelings. Effect always one: people don't hear what they are told, that is badly listen.

Lack of hearing. There is a set of the reasons for which people don't listen to speaking. Many of them are quite simple: the person doesn't listen when he was tired when he is upset with something or when the arriving information isn't interesting to him, sometimes to listen just to laziness. However to the fact that the person can't listen, eat a variety of reasons which aren't always obvious.

1. The person doesn't listen when it is excessively busy with own speech. For this reason to try to outvoice senselessly in a quarrel or a dispute of the opponent, reasonably, having listened to him, to provide the arguments.

2. Wrong representation that to listen − means simply not to speak; hearing − is the active process requiring continuing efforts, considerable attention and concentration on a conversation subject.

3. Hearing is absent when the person is absorbed by itself, the experiences, cares or problems; especially don't listen in critical moments of life when it is advisable to listen.

4. People don't listen just because don't want. As it was already noted, hearing always assumes desire to listen. At the separate moments, of course, everyone can distract from a conversation. Attentive hearing is hardly possible in wild spirits or when at listening already there was a certain opinion on the discussed question. Besides, in a condition of nervousness or uncertainty the person can have a fear to hear what he least of all would like to learn about. Hardly also the one who considers himself the specialist of the discussed subject and has ready answers to all questions will listen carefully.

5. People don't listen as well because just aren't able to listen. The one who during forming of the personality is brought up in a family with low culture of communication are inclined to copy bad habits as, for example, the aspiration to talk over or interrupt the interlocutor, to interpret silence of another as hearing, to state hasty conclusions. Many begin to learn to listen only when it becomes necessary or when they understand that it in their interests.

6. One of the main reasons of inefficient hearing is tendency of people to judgments, estimates, approval and disapproval of statements of others, i.e., the first reaction of the person − this judgment of the phenomena from the personal line items. Very often, however, the reaction based on personal beliefs is a serious hindrance of effective hearing.

Irreflexive hearing − attentive silence when don't interfere with the speech speaking with notes. In case of irreflexive hearing the understanding can be expressed by means of various nonverbal manifestations. If in the course of irreflexive hearing there are certain notes to the speech of speaking, it is necessary to express them very briefly and, whenever possible, neutrally. Anyway, answers in case of irreflexive hearing shall be minimized type: "Yes!", "How about that!", "Continue", "Interestingly", etc. It is possible to allocate a number of situations in which it is reasonable to apply irreflexive hearing as more useful and effective:

− at stages of statement of a problem when it is only created by speaking;

− when the interlocutor shows such feelings as anger or a grief;

− when the interlocutor shows big motivation to express, is eager to state the point of view;

− when the interlocutor gathers (wants) to discuss urgent problems.

− when speaking is initiated, hardly expresses the thoughts or experiences difficulties in expression of the problems;

− in case of communication with timid people;

− when holding a medical interview.

The psychological features reducing communicative competence of the doctor. Professional activity of the doctor is connected with development of strategy and tactics of therapeutic impact and, therefore, requires ability to predict events, to anticipate possible options of development of a disease, a complication, a consequence of pharmacological treatment. With respect thereto presence at the doctor of such characteristic as uneasiness which influences his prognostic opportunities is important, carrying out both an adaptive, and role which breaks adaptation depending on expressiveness degree. Intensive degree of emotion of alarm (fear, panic, horror) carries out the disorganizing, destroying function in relation to cognitive activity, paralyzing productive work of mental processes.

The intensive alarm disturbs:

− it is adequate to assess a situation;

− to determine possible options of its development and to choose the most correct under these circumstances the decision;

− interrupt communication of the doctor with the patient;

− destroy psychological contact between the doctor and the patient;

− the alarm of the doctor "is transferred" to the patient and will disorganize him;

− under the influence of alarm various functions of an organism owing to what there can be frustration of a dream, a loss of appetite, or, on the contrary, its increase are broken (some patients in a condition of alarm have a bulimia);

− the doctors inclined to react to any changes by increase in alarm are usually unattractive for patients who prefer stable and emotionally balanced doctors.

The doctor having tendency to depressive reactions has no credibility the patient. Observing as the attending physician reacts sense of guilt to any, most insignificant failure, inaccuracy, a mistake, the patient begins to suspect him of incompetence, ceases to trust it. The doctor shipped in own experiences cannot notice, on the one hand, improvements in the patient's condition, in time not support him, having emphasized recovery symptoms, and on the other hand, "to infect" the patient with sad hopelessness, to destroy positive effects of the carried-out therapy***. The doctor-introversive personality*** shipped in the psychological world, occupied by herself the feelings, the ideas, impressions, is interested in other people a little and finds helplessness in the situation requiring interaction and a cooperation with people around. The isolation is followed by a lack of an intuition, keenness, tactfulness in the interpersonal relations, an insufficient capability to respond to pain and suffering of another, to respond on his concern and alarm. Acting as the "communicative barrier" interfering effective communication, this quality is capable to reduce communicative competence of the doctor.

How the doctor can aim at achievement of mutual understanding in a conversation with the patient? The lexical consensus is reached if speaking uses those words templates which application during the previous meetings helped to find a common language in a conversation even if in this case it was possible to express the thought much more simply and more clearly. In this context the first meeting of the doctor with the patient which result depends on its installation on achievement of mutual understanding is of particular importance. The style of communication which is accepted by the doctor in case of the first meeting will determine further constructibility of communication in general. For effective information transfer: clear up the ideas before their transfer; exclude ambiguous words; you watch intonation of a voice, language of own poses, gestures; radiate empathy and openness; try to obtain establishment of feedback.

8.3. Restrictions of process of communication in health sector

Communication challenges in health sector. Some people are absolutely unreceptive to information concerning health issues. They firmly adhere to the views and reject all new. Intensive communication can suppress a susceptibility and cause rejection of information. Influence an environment (a family, friends, fellow workers) can appear an obstacle for perception of knowledge also.

A number of the factors limiting communications in health service: it isn't enough resources, a shortcoming of professionals, lack of an opportunity to organize work on a health-saving on a long-term basis. In case of nonprofessionally organized process of communication establishment of partnership isn't possible.

Restrictions of process of communication in health sector:

1. Restriction of resources and project nature of financing, first of all, in relation to the projects devoted to healthy lifestyle. Long-term prospects for assistance to preservation and promotion of health aren't priority as the majority of projects aren't expected longer period, than from 1-3 years.

2. Absence of the professional specialist in the organizations of health service which are engaged in informing the population on health issues; lack of strategy and planning of communication; the subjects responsible for communication aren't determined or not clear (responsibility is divided between several participants, and collateral actions aren't successful).

3. The need for promoting − isn't present skills of submission of information in a popular, available and laconic form.

4. Expectation of priority of illumination of questions on preservation and promotion of health in media on an equal basis with other socially important problems. Media are engaged in search of the news and sensations capable to draw public attention. Often information about health doesn't join in a significant number of messages in a general information flow.

5. The mythologization and a stereopization of public consciousness − at people exist resistant wrong beliefs (for example that in vodka of calories it is less, than in beer), and in case of receipt of true and professional information about health internal protective mechanisms are started and there is a rejection that can lead subsequently to problems with health.

6. Misunderstanding of need of long-term work on one problem from all subjects of communication in health service. Media often mistakenly consider that health issues are taken already up in full, the specialists acting as information sources about health don't consider it urgent and don't disclose the new aspects requiring professional opinion. The population, in turn, shows the low level of knowledge (though nominally it is high), to interest and responsibility for own health.

Topics of reports, abstracts and creative projects

1. Business communication in professional activity of the doctor.
2. Technology of overcoming communicative barriers.
3. Interpersonal communication of the doctor with colleagues.
4. Emotions in work of the doctor.
5. Conflicts in the medical environment and way of their permission.
6. Features of professional interaction of doctors, communicative barriers at communication with colleagues and ways of their overcoming.

9. MODERN TECHNOLOGIES OF INFORMING OF THE POPULATION AND PATIENTS

9.1. Medical information as suited communications in realization of the main objectives of health service.

9.2. Practical ways of adaptation of the text and information messages.

9.3. Publications and performances in mass media.

9.4. Press conference, the press release, articles, interview, the comments concerning questions of health of the population. Electronic mass media - television, radio; printing mass media - newspapers, magazines, professional editions, printing editions of the organizations, amateur editions; Internet and e-mail; Internet mass media (social networks); advertizing.

9.5. Organization and participation in actions for carrying out the World Days of health.

9.6. Organization «hot lines», «round tables», participation in press conferences, carrying out seminars, the edition of popular scientific literature, carrying out facultative occupations, lectures, trainings in education establishments.

9.1. Medical information as suited communications in realization of the main objectives of health service

Depending on character, the contents and scope of application medical information is subdivided on:

− scientific − data from the scientific and professional publications, reflecting to adequately current state of a medical science and practice objective regularities in the field of medicine, health service and related fundamental and applied scientific subjects;

− information arising in the course of rendering of medical care and reflected in medical documents, statistical information;

− public information on health service questions (official information on policy in the field of health service, sociological information on requirements of the population in medical aids, and also the popular scientific

medical knowledge focused on formation of bases of a healthy lifestyle of the population);

− information and advertizing and tactical information (data on new technologies, preparations and equipment of medical appointment and environment of the medical market).

Medical information is necessary for decision-making on any of levels of management of health service; it is the general and valuable resource which, as well as other resources, it is necessary to plan, regulate, finance and renew.

Scientific medical information includes all types of scientific medical literature, scientific and technical documentation (primary information sources), and also all types of secondary information sources which mainly contain information on the maintenance of primary information sources. Scientific medical information includes data from medical publications.

Promptly increasing flow of information (often called by information explosion), creates problems among which difficulties in search of necessary information, physical difficulties in development of all flow of information on any medical subject and need of an assessment of quality containing in them scientific medical information are the most essential; language and terminological difficulties at expansion of medical lexicon; delay in development and use by consumers of already published scientific medical information.

Informatization − the organizational, social and economic and scientific and technical process providing conditions for formation and use of information resources and realization of information relations (From the Law of Republic of Belarus from November 10, 2008 of No. 455-Z «About information, information and protection of information»).

Defining tendency of world development − universal introduction of information and communication technologies to all spheres of human activity − the public and local administration, production of goods, health service, culture, a science, the social sphere etc. An actual problem of modern health service, the key moment in achievement of efficiency of its infrastructure is information − common information space creation for all interested parties: patients, doctors, organizations and governing bodies health service.

The main sources of information about health:

1. Official structures of health service (Ministry of Health (<http://minzdrav.gov.by/>) and Ministry of Labor and Social Protection (<http://mintrud.gov.by/ru>), management of health service of regional executive committees and so forth), organizations of health service, establishment of medical education (<http://www.vsmu.by/>);

2. Experts treatment-and-prophylactic, research establishments and branch organizations;

3. Results of scientific researches;

4. Non-profit organizations in health service and a partner network (culture, sports, education and so forth);

5. Special literature: managements, grants, instructions;

6. The Internet - at work with Internet resources it is important to check reliability and reliability of a source of information, to consider pluralism of the points of view, to exclude to (minimize) lobbying of interests of commercial structures;

7. Commercial structures − in the conditions of development of the market relations possibility of implementation of interaction with commercial sector (on various conditions) is not excluded.

9.2. Practical ways of adaptation of the text and information messages

Only available and accurately formulated information will reach target audience. Therefore information intended for wide audience should be stated in the most popular form.

It is possible to translate the language sated with medical terms into usual language and to make clear the same as it occurs when translating foreign speech. Sometimes and simple "transfer" happens insufficiently, the text needs to be copied anew, to simplify, reduce, or, for example, to illustrate by means of ordinary examples or addressing directly to the reader or the listener.

Ways of adaptation of the text:

1. Translate or explain loan words. It is possible to translate terminology in the same way as translate from a foreign language. Use, for example, instead of the term "atherosclerosis" the phrase «narrowing of a gleam of blood vessels», and instead of «the maintenance of lipoproteins » speak about the content of fats.

2. Explain terms and open difficult concepts. For example, terms LDL cholesterol and HDL cholesterol difficult give in to transfer, but it is accepted to speak about them, as about "good" and "bad" cholesterol.

3. Refuse difficult syntactic designs and use short simple sentences (especially in oral speech). Random access memory of the person in a condition to form the phrase at most of 15-20 words.

4. Reduce the text, it is not necessary to open more exhaustively any question that at the listener or the reader interest to a subject remained. Sometimes it is necessary to offer details that the main point became more clear.

5. Illustrate a contemplated problem by means of examples from an everyday life, it will allow the person to join in a discussed subject completely. Personify the address to the listener or the reader, show, for example, that the healthy lifestyle can give to this specific person. For example, smoking of tobacco leads to increase of arterial pressure and if the

person gives up smoking, pressure will decrease. Do not speak about that, in what diabetes treatment manages to society, but count, how many it costs to each person.

6. State a material so that it was fascinating. Tell story, for example, the specific person or use a role model. An effective context of perception can be the story about any known person who managed to change something in a way of life and to get rid of problems with health. Personal experience develops of bright examples of life of an environment of the person (a family, friends, acquaintances, celebrities and so forth).

7. Even replacement of a passive grammatical design active does a stated question closer to the person (instead of «ointment is put» tell «put ointment»).

8. Instead of negative images use positive examples and models to which are to be followed («Your skin becomes fresh and shining when you will give up smoking» instead of «If you smoke, you will develop a cancer of skin that is at the bottom of lethal outcomes»).

9. Try to be original. Be courageous. A good example is national movement «Revolt against a hangover» in Finland. Participants of movement call in question the situation occupied by alcohol in society, and loudly fight, first of all, against the advertizing of alcohol addressed to youth.

10. For formation of motivation awakening of the emotions is necessary, one only has not enough information. Researches of activity of a brain showed that the person makes decisions on the basis of emotions and only later finds the rational reason. For example, if the person gives up smoking, he feels pleasure and satisfaction of that it managed to make it. And later he feels it physiologically (sense of smell, skin color, a condition of hair and nails etc.) that improves subsequently and considers as a rational cause of failure from smoking.

11. Use at illumination of questions of health of receptions of advertizing is allowed. It is necessary to awaken strong emotions (e.g., empathy).

12. The person plunges into a condition of "flow", being in which it sees only the purpose (sees that he looks good) and changes the behavior (grows thin), applying for an award (success). The purpose thus should be real and deserving fight for an award.

13. Be tolerant and treat with understanding to values of target audience even if they differ from your own, for example, religion or distinctions in a way of life of residents and provincials (urban and country people).

14. Repeat told earlier. Remember that the volume of communication should have reasonable borders, and excessive communication in the sphere of health service can dull perception.

15. The accurate formulation helps to understand the contents.

16. Information can be recovered and made more interesting by means of illustrations, drawings and schedules which will essentially facilitate perception.

9.3. Publications and performances in mass media

Mass media (mass media) provide a regularity and a prevalence of information and thanks to it are the powerful mechanism of impact on mass audience ("fourth estate").

Expansion of a medicalization strengthens medicine function as social control.

Medicalization − process during which there is a distribution of influence of medicine on all new spheres of public life. It is characterized by penetration into mass consciousness of medical language and style of thinking, medical concepts and ideas of the reasons, forms of course and treatment of diseases, increase of dependence on medicine of an everyday life and activity of people, fixing of medical "labels" to some human properties or behavior types (the disabled person, the addict, the alcoholic etc.) which can promote an exception of branded persons of process of normal social interaction. Production and use of medical "labels" in social practice can have and stratification character because of possibility of assignment of the status and definition of belonging to the group having social privileges or social restrictions (up to isolation). [Gritsanov, A.A. et al., 2003].

The special role belongs to mass media which are capable as to stimulate improvement of quality of medical care, to interest of patients in cooperation with medical workers in fight against an illness, and to insinuate and disappointments at consumers of medical services. Therefore optimization of relationship of mass media, doctors and patients in processes of a medicalization is an actual social problem.

The positive role of mass media in a medicalization consists in a) participation in preventive work, b) implementation of the main volume of information activities, c) positioning of as a link between the called agents of a medicalization.

Optimization of relationship between patients, doctors and mass media is connected not only with consecutive independence of information channels, but also with increase of trust of patients to mass media, active cooperation with them medical workers.

The social partnership of doctors and mass media directly influences a commitment to treatment of patients. The same mass media can and should play a positive role in distribution of medical knowledge, formation of installations on a healthy lifestyle. They initiate the related activity cannot, since are institutionally independent of medicine and health service. Therefore, medical workers should assume this role.

In a bigger or smaller measure and owing to the professional duties, practically each doctor is the popular writer of medical knowledge. First of all, in this quality it proves in communication with patients and their relatives in need of available and simple in a form of a statement of results of special inspection, the diagnosis, the scheme of the forthcoming treatment, recommendations about an individual mode of an everyday life, etc.

New tendency in scales, ways and forms of promoting of medical knowledge is sharp increase of specific weight of the materials shining various scientific-theoretical and applied aspects of medicine in unspecialized mass media. Now and, with rare exception, in the majority of the countries almost all not medical magazines, newspapers and the Internet portals focused on mass audience, have the constant headings devoted to questions of health of the person or publish such materials periodically. Acquaintance with publications in these headings testifies that their considerable part is borrowed from casual sources, often contains inconsistent and yet not approved by a science and clinical experience "sensational" data. Many publications have frankly advertizing character and without the sufficient bases propagandize new drugs, ways of treatment, every possible food additives, etc. Permission of this problem consists in optimization of interaction of mass media and medical workers.

9.4. Press conference, the press release, articles, interview, the comments concerning questions of health of the population. Electronic and print media, professional editions, printing editions of the organizations, amateur editions; Internet and e-mail; Internet mass media (social networks); advertizing

National and world information resource on health service and medicine is very extensive and constantly changes, and also as sources of scientific medical information contain, except documentary, statistical, administrative, legal, standard and other types of information.

Scientific documents can be subdivided on primary and secondary, published and unpublished. The scientific documents which are directly fixing the contents and results of research and developmental activity are primary. The scientific documents representing result of analytical and synthetic processing of primary scientific documents are called as secondary.

Primary documents include monographs, textbooks, the managements, scientific notes, collections of scientific works, theses of reports of scientific forums, methodical and directive documents, publications in newspapers and magazines (for example, the magazine «Questions of the organization and health service information»), special types of technical editions (patent information, state standard specifications, industrial catalogs, algorithms and programs). To the primary carry and not

published documents (the dissertations, the deposited manuscripts, transfers, pre-prints, reports).

Secondary documents are reference books (encyclopedias, dictionaries etc.), information publications (bibliographic, abstract and survey information), catalogs and card files.

The main advantage of electronic sources of information with reference to health service is that the majority of them provides access to integrated information:

1) about medical literature;

2) about medicines and the medical equipment,

3) about specific patients,

4) about indicators of health of the population (statistical information),

5) about administrative decisions (directive, standard and legal information).

Press conference. Now the flow of information is very intensive, therefore it is necessary to analyse volumes and the content of communication accurately. It concerns also press conferences which are for officials almost the most widespread way of expression of the point of view. Press conferences carry out also various organizations which are engaged in public activity.

In the health service sphere carrying out press conference is reasonable if it is necessary to shine, for example, new results of scientific researches, to tell about epidemic posing threat to human health or to begin any promotional campaign. At the same time it is not necessary to arrange press conference, if there is no of interest new information.

Conditions of carrying out successful press conference:

− Send invitations in edition in 3-7 days prior to day of carrying out press conference;

− Think over the press conference scenario;

− In the invitation specify a subject, a place and carrying out time, and also present with the indication of their profession, a position;

− Specify structure of participants and after that provide some occasional seats;

− Agree in advance who answers questions of this or that subject;

− Leave time for questions of journalists and for separate interviews which can be necessary for mass media;

− Time of carrying out press conference should make no more than 1 hour.

It is necessary to mean that press conference materials, can be used by journalists for article writing.

Press release. The press release is the most widespread and fast way of submission of information. The press release should contain reliable

information which can be published or on the basis of which to write a material or to do pass. It is possible to process press releases, adding information or reducing it.

Effective press release:

- it is short, volume no more than one page of the A4 format;
- answers questions: what? where? when? how? why? and who?;
- contains news and tells about it at once at the beginning of the text;
- the bright heading corresponding to the contents;
- tells, who is the sender of information and where it can be found;
- tells, who can present additional information if necessary;
- contains embargo (information "expiration date").

Article, interview, the comments concerning questions of health. The questions concerning diseases and their prevention and treatment, cause wide interest. Often meets that doctors make comments on topical issues of health or give interview for mass media. In the majority of newspapers and magazines there are headings in which opinions of readers and experts are published.

Journalists with a great interest cooperate with professionals, experts in the health service sphere. Badly organized communication can spoil good undertaking therefore to interview, it is necessary to prepare carefully and in advance. If article written by the expert are going to publish in the printing edition for laymen, the author should give editions permission to edit the text with the point of view of style, to make it if necessary more popular if the author himself cannot or does not manage to make it. However it is important to coordinate a published material in order to avoid mistakes and defects. It is necessary to include statistical data, results of researches and other materials which are available only to professionals.

At a choice of a subject of article it is necessary to pay attention to the following:

− subject urgency, news value;
− exclusivity;
− popularity, compliance to interests of a wide range of addressees;
− a professionalism in a statement, clearness;
− critical relation − multilateral independent coverage of the topic.

Electronic mass media. Annually in the world on problems of medicine there are millions the publications, over 15 thousand periodicals (in 80 languages), more than 300 abstract magazines collect on the pages of data approximately about 80 % articles published in the various countries, theses of reports, patents, dissertations and other materials. The wide circulation was received by the electronic magazines, the automated databases, expert systems, and also databases, knowledge bases and the separate selections of information existing only in an electronic form and extended on INTERNET channels and e-mail.

One of advantages of high level of communication in INTERNET is ability to form networks and projects together with colleagues and to participate in global process of joint decision-making. Being connected to the INTERNET network, practicing medics communicate about new achievements and opening, clinical cases, treatment protocols, possibilities of employment and carry out correspondence consultations. The INTERNET network showed the ability to provide medical information of multimedia to directly ordinary medical institutions. Sound, graphic and the INTERNET video files model real situations and create an optimum mode of training.

Internet mass media (social networks) - pages in VKontakte, Facebook, Twitter, Instagram:

− virtual meeting place of people, public space;

− replace e-mail as the channel of distribution of information

− it is possible to participate in quality of the organization, official body or the individual.

Advertizing (lat. «reclamare» − to shout) − distribution of data on something or about someone (as a rule, about the goods, the person, of the organization) on purpose to draw to them mass attention. In the communication devoted to questions of health, it is possible to use strategy and instruments of advertizing, for example, when planning information messages and information blocks.

9.5. Organization and participation in actions for carrying out the World Days of health

The world Days of health are celebrated in day of creation of World Health Organization − April 7, 1948. Annually this day for the purpose of awareness and drawing attention increase concerning any important problem of global health service the international, regional and local events will be organized. The world day of health gives unique opportunity to direct attention on a problem, to unite all interested to put questions and to define ways of their decision for preservation and strengthening of health of all generations.

Every year for the World day of health the subject reflecting any priority area of public health service gets out. This day people from all communities have an opportunity for participation in actions which can promote health improvement.

There are many kinds of activity, actions and strategy which can show actions and decisions within campaign of the World day of health. Actions or initiatives should promote participation of the various organizations or groups as it is one of main objectives of campaign of the World day of health − an exit for a framework of sector of health service for the purpose of ensuring long impact of these actions on health of citizens. Competitions and competitions, campaigns for posting by school students,

university forums, go-ahead races for the staff of the companies, campaigns for cleaning of the territory, fair of health, a meeting with the management of the city, area, the republic concerning health service on places − all these types of actions which can be organized.

In 2017 The World Health Organization (WHO) decided to make a subject of the World day of health the help to the people having a depression. It will pass under the slogan «Let's talk». According to WHO, the depression and disturbing frustration annually cause to global economy a damage of $1 trillion WHO decided to pay special attention to three groups which are subject to an extra risk: teenagers and youth, women of genital age (especially after the delivery) and elderly people (60 years are more senior).

9.6. Organization «hot lines», «round tables», participation in press conferences, carrying out seminars, the edition of popular scientific literature, carrying out facultative occupations, lectures, trainings in education establishments

Organizational, methodical and information and educational work includes:

− carrying out scientific and practical conferences, meetings of scientific organizations, development and the edition of grants for doctors, educational and methodical recommendations for work with the population, and also information state-of-the-art reviews for the aid to experts;

− development and the edition of facultative educational training courses, for example, «Healthy − it to be fashionable», grants for pupils of the comprehensive schools devoted to development of health saving behavior, to preservation and health strengthening;

− preparation of methodical recommendations and grants for specialists of treatment-and-prophylactic institutions;

− use of printing editions, cable television, means of evident propaganda;

− the organization of work telephone «hot lines», "telephone hotlines", "straight line" on which consultations of experts are carried out;

− carrying out On-line - conferences;

− for population informing concerning formation of a healthy lifestyle demonstrations of films, videos of the preventive contents, electronic sanitary bulletins, social advertizing, including on city TV and light-emitting diode screens are used; demonstrations of films in educational institutions; organization and carrying out multimedia presentations and videos;

− press releases about carried-out actions take place on official WEB SITES of the organizations of health service;

− actions, trainings (for example, «Do not take away from itself tomorrow», «School − the health territory», «A health marathon», «All life ahead», «Life in the world with world around», «Ecological relay race − from

the area to the area», «On foot for work», «Check the health», etc.) are conducted;

− exhibitions and stands take place thematic;

− «health lessons», conversations, lectures, seminars on promotion of bases of a healthy lifestyle, thematic discussions, debates, quizes.

Topics of reports, abstracts and creative projects

1. Advertizing as a source of informing of the population about health and healthy lifestyle.
2. Internet mass media (social networks) as a source of informing of the population about health and healthy lifestyle.
3. Medical newspapers, magazines and professional editions of physicians of Belarus.
4. Carrying out the World Days of health as way of promotion of healthy lifestyle.
5. A positive role of mass media in population informing concerning health.
6. Modern technologies of informing of teenagers about health and a healthy lifestyle.
7. Printing mass media as information sources about health.
8. A role of mass media in a society medicalization.

10. FEATURES OF COMMUNICATION WITH PATIENTS WITH VARIOUS NOSOLOGICAL FORMS OF DISEASES

10.1.Ethic and deontological problems of interaction of medical workers with patients with various nosological forms of diseases.

10.2.Behavioural and communicative skills of communication of the doctor with patients with malignant new growths, HIV infection and other social and significant diseases.

10.3.Basic principles of communication: partner relationship, focusing on priorities, requirements and the point of view of the patient, a self-control principle.

10.1. Ethic and deontological problems of interaction of medical workers with patients with various nosological forms of diseases

As a result of a disease values are quite often overestimated, the relation to life, work, to relatives, to changes. The patient suffers not only physically, but also grieves. The modern therapeutic patient differs the following features: existence of several diseases at the same time; high frequency of neurosises; large quantity of allergic diseases; obesity; chronic infections; high relative density of a warm and oncological pathology;

escalating number of urgent conditions; growth of medicinal dependence and pathology.

Characteristic feature of chronic diseases is their irreversibility, secondary defects, complications, inferiority of the individual. It is possible to allocate 2 groups of chronic diseases:

1. Long, demanding restrictions (e.g., diabetes);
2. With a deadly outcome, for example, tumors.

The illness which has become chronic, becomes also a personality component, is built in it: all thoughts of the person are interfaced to an illness, become selfish, their surrounding events interest a little, and all connect with the illness and a forecast. Value of all this is strongly exaggerated. People become quick-tempered to all healthy, sensitive, envious.

The relation to an illness develops from***: Illness understanding → the Experience connected with an illness → of Behaviour during an illness.***

For patients with various diseases of an internal specific emotional reactions are peculiar. So, for frustration of action of the heart sensation of fear, for violations of function of a liver - indifference or even disgust to surrounding, and sometimes irritability, for stomach diseases − irritability, a conflictness, grumpiness is characteristic. These reactions complicate a clinical picture of a disease and its current. Depending on type of the identity of reaction to a disease can be different. It is necessary, that the doctor knew the relation of the patient to an illness and chose the corresponding psychological approach. One patients strengthen, exaggerate semiology. Some for mercenary reasons can think out in general to themselves symptoms - feign. The third in every way hide painful manifestations the disease.

Distinguish 6 types of reaction to an illness:

1) asthenic, being shown in the form of the raised exhaustion, faintheartedness, tearfulness, slackness;

2) depressive, being characterized feeling of alarm, melancholy, confusion, loss of hope of recovery, absence of motives to illness overcoming, feeling of a hopelessness and humility;

3) the hypochondriac, being characterized «life in an illness» which subordinates to itself all interests and desires of the person;

4) disturbing and hypochondriac, being shown mistrust to appointments of the doctor, search of remedies in medical literature or at people around; they easily form different phobias: fear of a cancer, fear of venereal diseases, etc.;

5) the hysterical, being characterized fast change of mood: that cry, catch at pulse, feel a breast, a stomach, declare that they die. Can calm down and switch quickly enough the attention to external factors. In a family and on work speak about the condition much, colourfully describe the sufferings.

Some have a tendency to imagination and there are all new details of their illness, and start to believe in their reliability. The mimicry expresses "torments" and "sufferings". Constantly complain of misunderstanding and insufficiency of attention from relatives;

6) illness replacement at which patients ignore a disease, do not wish to be treated. Quite often it happens at physicians.

At each patient the vision of the disease which have developed at it is formed: its reasons, its weight, its main manifestations and outcome. An internal picture of an illness or still it call an autoplastical picture of an illness, in effect is a picture of subjective perception her patient. . An internal picture of an illness has the following parties (or components):

− sensitive (local pains and frustration),

− emotional (fear, alarm, hope),

− strong-willed (efforts to cope with an illness, with inspection and treatment),

− rational, informative (knowledge of an illness and its assessment).

The autoplastical picture of an illness can be caused by the following reasons:

− character of a disease (sharp, chronic, severe pains, mobility restriction, cosmetic defects and so forth),

− circumstances which accompany a disease (the arisen problems and uncertainty in the future, changes in a house situation and relationship and so forth),

− previous disease features of the personality (character, age, social status, previous diseases, etc.).

It is necessary to remember that between weight of a disease and number of complaints of the patient quite often there is a feedback: when the disease accepts the most difficult organic character the number of functional complaints and on the contrary decreases, the disease is heavier, the it is more and the complaints are more colourful. Each patient can possess unusual reactions, properties of an organism or a clinical course. 1/3 patients addressing to the doctor has not somatic diseases, and neurosises. Some call 60 % − emotional, instead of physical experiences. Even, if the organic disease is found, not always the clinical picture is caused only by this disease. And at any neurosis − it is possible to find an organic disease.« Often much it is more important to know not that on R-gram, and that at the patient in the head». The most frequent situation − stratification of neurotic frustration on a somatic disease. The clinical picture appears mixed, unusual, not keeping within a usual framework − complexity of the differential diagnosis. They often "unclear".

Each person, entering the status of the patient, gets certain rights and has the duties.

Each patient has the right on:

− receiving qualified, timely and (in our country) free medical care;
− choice of the attending physician and health service organization;
− participation in a choice of methods of rendering of medical care;
− stay in the health service organization in the conditions corresponding to sanitary-and-epidemiologic requirements and allowing to realize the right to safety and protection of personal advantage;
− the valid and humane relation from workers of health service;
− receiving in an available form of information on a condition of own health, applied methods of rendering of medical care, and also about qualification of the attending physician, other medical workers who are directly participating in rendering to it to medical care;
− a choice of persons to which information on a state of his health can be told;
− refusal of rendering of medical care, including medical intervention, except for the cases provided by the Law;
− the pain relief, connected with a disease and (or) the medical intervention, all methods of rendering of medical care taking into account medical and diagnostic possibilities of the organization of health service;
− realization of other rights according to the Law and other acts of the legislation of Republic of Belarus.
− the admission to it of the priest, and also on granting conditions for departure of religious practices if it does not break regulations for patients, sanitary-and-epidemiologic requirements.

Granting to the patient of the specified rights cannot be carried out to the detriment of health of other patients and break their rights and freedom.

The patient is obliged:
− to care about own health, to take timely measures for its preservation, strengthening and restoration;
− to treat workers of health service and other patients validly;
− to carry out the recommendations of the medical workers necessary for realization of chosen tactics of treatment, to cooperate with medical workers when rendering medical care;
− to report to medical workers about existence at it of the diseases representing health hazard of the population, a human immunodeficiency virus, and also to observe precautionary measures at contacts to other persons;
− to inform medical workers on earlier revealed medical contra-indications to application of medicines, the hereditary and suffered diseases, about requests for medical care, and also about changes in a state of health;
− to observe regulations for patients, to make thrifty use of property of the organization of health service;
− to carry out other duties provided by the Law «About health service» and other acts of the legislation of Republic of Belarus.

(Extraction from the Law of Republic of Belarus «About health service» − Art. 41. Rights of patients / Art. 42. Duties of patients).

Thus, to each patient it is necessary to treat with sufficient respect and attention, tone of command, a humiliation, as is inadmissible from doctors, so average and younger medical staff. On the other hand patients also should observe the moral duties in relation to doctors and the medical personnel: to show consideration for the health, to report all truth about the illness, ready to be productive to cooperate with the doctor. The patient should be polite and tactful with people helping it, is obliged to show to them gratitude and respect. Violation of ethics is concealment of important aspects of a disease, for example, alcohol intake, drug addiction, etc. By no means the patient should not self-medicate and furthermore to give advice another or to try to treat procedures, analyses, appointments to other patients. Such actions can lead to harmful consequences.

The special contingent of patients is represented by children. They are extremely sensitive to all circumstances accompanying a disease. The reasons causing considerable changes in mentality of the child are:

− depending on a disease form: hypoxemia, intoxication, allergy, reflex (painful) influence;

− a separation from a family, schools, friends;

− new irritants of a hospital: inspections, medical procedures, mode and so forth.

As a result at children pathological lines of the personality can easily be formed: egocentric, dependant, hysterical, hypochondriac, etc.

During an illness defects of education and character more brightly start to act. Shifts and as a result pharmacotherapy can develop: both psychological and chemical. Children till 7 years are easily exhausted, since cells of a brain and mentality intensively develop. It is necessary to consider that the mode corresponding to earlier age, owing to its weakening is necessary for the sick child. Various impressions and frequent contact to adults are necessary for creation for the child of good mood. At the same time children become attached to a situation and it is necessary to avoid transfers to other chambers, to contain in boxes and insulators, it is necessary to expand indications and age of hospitalization with mothers. But also not to create the selective relation to any children, to allocate "favourites". All measures it is necessary to avoid violence. It is desirable to create in group chambers on age and interests. In hospitals educational work should be well adjusted. Game always is very important element in education of children, and for preschool children collective games are especially important; drawing distracts them with painful experiences, has psychotherapeutic influence. Very important and reading "supporting", "stimulating" literature.

Thus it is necessary to remember that at children there can quickly come satiation one type of occupation. The importance has the correct

selection of toys, games and occupations. Children who are especially sick, need bigger sympathy, participation, love. Sharp or angry tone concerning children is inadmissible. The remark made silent, quiet, confident tone renders considerably bigger effect. The skilled pediatrist knows that the trust of the child is easy for losing, if him to deceive, for example, having calmed promises which are not carried out then. To any procedures and unpleasant treatment psychological preparation is necessary. The important place in a deontology of children's age is occupied by prevention and psychotherapy. Psychotherapy somatic sick children integral part of all complex of medical actions. At the child it is impossible to count on conscious overcoming of fear or pain, on strong-willed effort. It imposes on medical workers special responsibility in careful comprehension of necessity of this or that manipulation or procedure. It is impossible to allow notification of the child about danger of an outcome, weight of a disease. But it is impossible to hide it from parents. Therefore, big explanatory and psychological work should be carried out with parents.

Relation of the doctor to treatment of elderly and aged people − always very exact and sensitive indicator of its ethical potential, deontological positions, moral qualities, humanity. To some doctors, claims of the elderly person for active treatment and desire to be completely healthy seem especially young unclear and even unethical, it is good to feel and to conduct still an active way of life in every respect. Often on these inquiries the answer follows: «Rejuvenate we you we can not», «To you any more 20 years» to the t is necessary for doctor to show attention and respect for certain habits, a household, hygienic stereotype of the old person, to help to facilitate many «specific household difficulties» in hospital, remembering how it is difficult to change to older persons in hospital the stereotypes. Elderly and aged people are similar to children − they are sensitive, tearful, garrulous, many lines "are pointed". In old age of a disease is much more often chronic, flow inertly.

Features of treatment of aged patients:

1. It is impossible to break powerful medicines established compensation.

2. Less than such procedures, as sounding of veins.

3. An aging basis − dehydration, from here a therapy basis − hydrotherapy, a removal of toxins, microcirculation improvement - in capillaries of 80 % of blood of all organism. From a set of diseases to treat the main thing.

4. Strict identity of treatment. To appoint the drugs normalizing reactance and exchange processes.

5. Observance of a food, water and salt diet − for intoxication prevention from medicines, breaks in drug intake.

Good results of any researches should be told surely to patients − it is a good component of «motivated reassuring», stop on favorable pro-gnostic data, not establish in advance exact terms of an extract. Calming and encouraging estimates should be individualized and coordinated with a real situation and common sense, to observe a reasonable measure and not to apply the overestimated optimism.

The message of unpleasant information should be correctly presented. It is necessary to be able «correctly to place accents».

The general moments at the message of any diagnosis in any situation:

1. To be convinced that there is time if necessary to answer questions of the patient.

2. To report the diagnosis in a private comfortable working situation, it is desirable in an office of the doctor.

3. At the moment of the diagnosis message indoors there should not be the people who are not concerning medical diagnostic process of this patient.

4. To be convinced that with the patient there is a contact, it reacts to words of the doctor.

5. The doctor should have a possibility of the emergency help to the patient, in case of an acute reaction on information on the health.

6. The doctor should have paper and the handle to write down the words and recommendations for the patient.

7. The doctor should have additional printing materials for the patient with information on a disease, possibility to receive fast medical and a medico-psychological assistance.

8. To be short, but clear for the patient.

9. To be convinced that the patient understood your words and knows the next actions.

10. If necessary to transfer the patient under guardianship to the nurse or accompanying relatives.

The message of the usual diagnosis in a standard situation:

1. To carry out clinical survey of the patient, to collect the full anamnesis on the basis of which the hypothesis or the statement about the diagnosis can be put forward.

2. The option is possible - the patient came to reception after diagnostic actions and waits comments of the doctor on the diagnosis. In this case - to familiarize (to refresh in memory) the previous records in a medical record to study results of diagnostic actions on the basis of which the hypothesis or the statement about the diagnosis can be put forward.

3. To lift eyes from records and to look at the patient. During time the message of the diagnosis it is necessary to look at the patient openly and friendly, to watch his nonverbal reactions, first of all a mimicry.

4. To ask a verifying question, to be convinced that the patient in contact and hears the words turned to it. Verifying questions are directed on establishment of contact to the patient, instead of on collection of information about is mute. For example: «To you after reception it is necessary to go on work?». The task of the doctor - to receive the answer of the patient adequate to a situation in words or in actions.

5. If the patient contact, the doctor calls the diagnosis, looking in a face to the patient calls at first the medical formulation of the diagnosis, then, without waiting questions of the patient, tells the diagnosis, having conditionally translated it into not medical language available to understanding to the average person. The doctor is forbidden to assume that the patient and so knows that the medical formulation means. Any diagnosis should be repeated at household level, but is very short. Formulations are fulfilled in advance for each specialty and taking into account the contingent of the people addressing in this clinic. For example, the formulation «erosional gastritis in a remission stage» can be repeated as «a chronic inflammation of a stomach at which on the mucous small wounds are formed, but now there are no aggravation signs».

6. If the patient not contact, i.e. not absolutely adequately answers or operates (everything drops, falters about subjects, brakes with the answer, etc.), the patient needs to help to calm down. For this purpose the doctor needs to face openly to the patient and slightly (corners of lips and eyes) to smile.

7. To make a pause in conversation for 5-7 seconds.

8. To wait contact of the patient to the doctor eyes (the patient will face the doctor and to show interest).

9. To tell to the patient the diagnosis as it is described in item 5.

10. To ask to the patient questions: «To you the diagnosis is clear? You have questions according to the diagnosis?»

11. To make a pause, to wait response to a question.

12. To answer questions of the patient concerning the diagnosis, using clear not to the physician language and without pressing in big details.

13. To give to the patient a brochure/instruction with information on his disease or report, where it can find information.

14. At emergence of questions of a forecast of a current to pass to forecast discussion.

15. To pass to questions of discussion of treatment or diagnostics.

The difficult problem arises in the presence of a mental disease. Many chronic mental diseases do not cause aspiration to learn from the majority of patients the diagnosis. Rather, there is a question: «And how many I will be in this hospital?» The type answer «is so much, how many it is necessary for business» - it is not necessary, because it means for the patient: «how many I will want, so much and I will keep you here». It is perceived by it as

violence, tyranny, despotism. It is natural that after that contact of the doctor and this patient will not be. Therefore it is desirable for the doctor to discuss those symptoms which the patient is not inclined to reject, for example, sensation of fear, sleeplessness, headaches, irritability, feeling of alarm. It, as a rule, is accepted by the patient.

The medical organization should be the true house of health. The individual approach of the doctor for the good of the patient in each separate case is creativity of its personality, based on a combination of professional knowledge and properties of the identity of the doctor.

At an extract exact instructing with the instruction of a mode, a diet, medicinal therapy is necessary. Resistance to an extract arises for the following reasons:

1. The fear before relapse − is dependence on hospital.
2. Excessive hopes of hospitalization.
3. In hospital it is better than a condition, than the house.
4. Different mercenary reasons.

10.2. Behavioural and communicative skills of communication of the doctor with patients with malignant new growths, HIV infection and other social and significant diseases

The question of frankness with incurably sick patient is represented to one of the most difficult. In clinical practice this question includes "when" "as" and "how many" to tell to the patient about his diagnosis, elections of therapy and a possible forecast.

There are most different opinions in this respect. One think that the patient should tell all truth, others emphasize need of careful attitude to the seriously ill patient and speak nothing to it about coming nearer death, the third consider that it is necessary to behave how the patient wants.

The Soviet deontological principles were under construction that patients should not give full information. It regarding cases is represented rather reasonable. For example, the doctor deals with very hypochondriac patient inclined to heavy depressive reactions; accurate information issued to it on duration of his life can cause only heavy depressive reaction and worsen the course of a disease, reducing life term. But such approach had shortcomings: patients quite easily learned that doctors hide information on danger of their disease or on a possible deadly outcome and did not trust of.

Certainly, the patient has the right to know the truth about the real situation, and it is allowed to nobody to usurp its right, however it is worth to remember that «the right to know» is not identical «to a duty to know». Not all patients want to know the truth. The seriously ill patient of people can and not wish to know something concrete about coming nearer death, and people around are obliged to respect him a choice. The knowledge of is very frequent that there will come death soon, does not facilitate a condition of the

patient. When the patient categorically demands to tell, how many he needed to live, representing the most different, quite often enough rational arguments, people around should try to understand, feel that is hidden behind these words. Often reckless courage is imaginary. Demanding to state everything up to the end, the patient not so represents the reaction to the cruel truth. It is sometimes easy to notice that its requirement has rather formal character, and he at all does not wish to receive the exact answer as it deprives of it hope.

The majority of people agree that terminal patients have the right to be well informed on the situation. Besides, many agree that these patients have independence in decision-making for themselves concerning medical treatment and other problems including the end of life. To answer real interests of mortally sick patients, it is necessary to clear various questions and to find balance between «good commission» and "do not do much harm".

A choice, to what level information on his condition will be issued to the patient, should be under construction not on verbal statements of the patient, and on understanding of its personality. It is necessary to consider not words of the patient, and a habitual stereotype of its reaction in a difficult situation.

The content of medical secret which medical workers are obliged to store, two groups of data make: actually medical data and other information on private life of the patient. To data which the doctor has possibility to hide from the patient, only medical data, namely - the diagnosis belong. The right of the doctor not to report to the patient about his condition is that if is known to the doctor about a serious, deadly illness of the person, he is not obliged immediately and to report about it on own initiative. But in use of this right the doctor is limited. If the patient meaningly demands to tell to it the truth, the doctor should make it.

The dying person is capable to understand the situation and quite often wants to talk about the illness and death approach, but only to those who listens to him without superficial attempts to console. Therefore the adviser or the doctor should be able to understand competently desires dying and the imaginations connected with death and fears. It allows not only to listen to the patient, but also to help it to share thoughts on death, own indignation and that it will lose together with life.

The diagnosis message to patients with malignant new growths, HIV infection, etc. socially significant diseases.

1. Beginning conversation on the diagnosis, it is necessary to have in a stock rather long time (there can be some hours) on communication with the patient.

2. The diagnosis is reported, as a rule, by the doctor, but it can be and other authorized representative.

3. The patient should be located to hearing the truth about the diagnosis.

4. The diagnosis is reported after rather long preparatory conversation on the carried-out researches and available changes in an organism.

5. It is necessary to try to avoid medical terms which can be unclear or misunderstood by the patient.

6. The message of the diagnosis should not look as adjudgement.

7. It is necessary to be ready to manifestation various, sometimes very strong emotions of the patient: anger, despair, etc.

8. It is necessary to be ready to divide with the patient his strong experiences.

Diagnosis message to relatives. The legislation accurately does not define questions: who can report the diagnosis from relatives and for whom it is impossible. The doctor should make the decision individually each time on each this case, considering individual reactions of specific people.

10.3. Basic principles of communication: partner relationship, focusing on priorities, requirements and the point of view of the patient, a self-control principle

Communication interaction of the doctor and the patient is regulated by the deontological code providing the following rules:

1. Entering interaction with the patient, the doctor should leave behind a threshold all the personal alarms and experiences, sympathies and antipathies, political, religious, national views and belief, intolerance and traits of character harmful to business (fastidiousness, arrogance and so forth).

2. The doctor should sympathize with the patient always.

3. The doctor has no right to the hostile relation to patients.

4. The doctor should be sincerely attentive and we suffer.

5. The doctor should not lose hope for treatment of the patient and has no right to deprive it hope of healing.

6. The doctor should support an optimistic spirit of the patient.

7. The doctor should cause trust in the patient.

8. The doctor should be indulgent to strangenesses, belief, prejudices, beliefs of the patient.

9. It is necessary to give special attention elderly, and especially - to lonely patients.

10. Special requirements are shown by a profession to gynecologists, the pediatrists who are at the beginnings of life, oncologists and other experts who are quite often facing death.

11. Concerning relationship of the doctor and the sick child medical ethics approve need to consider feature of children's mentality that is

impossible without knowledge of children's psychology and bases of pedagogics of children's age.

12. The doctor should clearly, accurately and competently to state the thoughts.

In communication with the patient the accounting of the factors providing success of interpersonal communications is important. Communication of the doctor and the patient should be not simple information transfer, and to be carried out for the sake of elaboration of mutual understanding and a consent concerning medical tactics. Only at confidential partner communication of the doctor and the patient accurate feedback "patient doctor" is possible.

The important deontological task − to reduce influence of a hospital mode on the patient. Work therapy, an estetoteraphy, a biblioteraphy leaving in itself will help.

The doctor and the patient represent the whole system "doctor-patient " having the regularities and the dynamics:

1. Patient:

− influence of patophysiological processes on nature of subjective and psychological reaction of the patient;

− subjective features of the personality which can affects its objective condition.

Doctor:

− his emotions,

− its moral installations,

− his thoughts after the relation to the patient which should influence in turn the patient.

At inspection the doctor enters into direct contact to the patient and physically influences it. The patient should feel that it surveyed honestly and in details that will relieve the doctor of superfluous complaints. It is necessary to remember, as process of inspection of the patient is the beginning of therapeutic influence.

Important in daily routine work not to forget, the doctor makes what impression on the patient. Appearance of the doctor (the principle of self-control consists and in it) is important: the tidy, pure, ironed-out medical clothes (a dressing gown or a trouser suit); the convenient and practical footwear which is not creating noise; moderation and modesty in cosmetics and perfumery; accurate hairstyle. Nails, contrary to fashionable tendencies, should be short and well-groomed. Smile, quiet manner of communication, distinct sure speech. At patients neatness often associates with high professionalism.

It is necessary to create the comfortable and benevolent atmosphere. A lot of things depends on the organization of medical process. To behave in relation to the patient to the doctor it is necessary frostily, patiently, not to

give in on provocation and not to provoke most, to try to gain trust of the patient. To avoid stereotype in conversation and behavior. To accept the patient such what it is. Plans of the doctor concerning treatment and recovery of the patient should correspond with the plan of the patient.

Nevertheless the point of view of the doctor and the patient on his disease can essentially differ:

1. The doctor, first of all, looks for objective symptoms of a disease, and for the patient in the center there are its subjective personal feelings and the experiences caused by an illness. The doctor is obliged to show consideration for subjective complaints and to understand their nature, should catch, what real factors underlie these complaints, to find their objective or subjective, psychological reasons, to define possibility of their positive use at inspection and treatment.

2. The doctor is often interested in as much as possible complete inspection of the patient, and the patient aspires to avoid superfluous, especially injuring inspections quite often.

3. The doctor is important for diagnosing more precisely, and to the patient − as soon as possible to begin treatment and more effectively to be treated.

4. Quite often the points of view and concerning a kind and the form of carrying out of treatment can disperse, and also − to spend him permanently or is out-patient. Absence of due contact can lead to full discrepancy of these points of view and accordingly not to observance by the patient of that plan of treatment which has been offered by the doctor.

Conversation with the patient − it not simply conversation of two people, it should be conducted by certain rules. In conversation of the doctor with the patient should be met the following conditions:

− never it is impossible to allow, that the patient felt that you hurry up and at you on reception of 30 more people. you should give 2-3 minutes to the patient freely to be uttered and only then to try to direct conversation. thus the patient should feel that you interrupt his monologue just because you certain aspects of its condition instead of because you have interest.

− it is possible to use reception of switching of a monologue on dialogue, especially with hypochondriac, hypochohdrical and detailed patients.

− even in the conditions of saturated reception or big employment it is possible to give 3-4 minutes to elementary rough inspection: survey conjunctivas, palpation of a thyroid gland, lymph nodes, palpation of a stomach, pulse, measurement hell, stock-taking of hypostases, thyroid gland, lymph nodes, language. the academician of m of page at all said that to hear warm noise to it enough 2-3x second, but he always listens to not less than 30 seconds.

− the questions which are set by the patient should be simple and clear, be offered in his language.

− the reported diagnosis should be explained, be reported in common form without use of unclear terms. it is necessary to remember that many medical terms have ominous character. after conversation with the doctor the patient, for example, can ask: «as you can write out me when I developed vesicular breath».

− it is necessary to soften the truth with mercy, but not to palter. it will stimulate will to fight and recovery. not to use "offensive" diagnoses, for example "hysteria", it is better to replace «nervous overfatigue».

− it is not necessary to state preliminary presumable diagnoses.

− not to read medical documentation of the patient before examine it and will make the idea of a condition.

− never condemn mistakes of the previous doctors, thereby you discredit yourselves.

− it is necessary for doctors to set some questions of private life and of circumstances of life of patients. it is necessary to make idea of the identity of the patient and his problems (loneliness, unsuccessful marriage, loss of the loved one, the serious conflicts on work or in a family). the grief or melancholy can cause not only an acute reaction, but also in a current of a long time to change a hormonal background, to upset immune protection, to promote early progressing of atherosclerosis etc. it is impossible to isolate the patient from vital circumstances, but it is possible to remove the exaggerated fears, to encourage.

− the doctor for conversation with patients should develop at itself empathy - empathy to a psychological condition of other person. at the same time - steadiness of the doctor harmonizes a condition of the patient.

− the doctor should explain to the patient of a way and a problem of the forthcoming inspection and treatment, both on the next, and for more remote period that can prevent reactions of the patient to "prolonged" inspection or "ineffective" treatment.

− very important at repeated conversations to pay attention of the patient on semiology mitigation.

− it is necessary to remember that each meeting of the doctor with the patient contains psychotherapeutic influence.

Topics of reports, abstracts and creative projects

1. Reactions of the patient to an illness and action of the doctor.
2. Communication of the doctor with the patients having welfare distinctions (representatives of racial, ethnic, sexual, religious minorities, foreign patients).
3. Equipment of communication of the doctor with hostile the adjusted and asocial patients.

4. Communication with depressive patients and patients with suicide intentions.

5. Rights and duties of the patient.

6. Ethical right of the doctor to cancellation of resuscitation actions.

7. Children as special contingent of patients.

8. Communicative skills of the doctor in work with elderly and aged people.

11. FEATURES OF COMMUNICATION IN PALLIATIVE MEDICINE. RECOMMENDATIONS AND POLICY OF WORLD HEALTH ORGANIZATION (WHO)

11.1. Behavioural and communicative skills in palliative medicine. Features of communication with patients, relatives of patients and colleagues in hospices, offices of the palliative help of versatile hospitals and oncological clinic, out of the health service organizations.

11.2. The main recommendations and policy on rendering of medical care according to WHO recommendations.

11.3. Prevention of reactive depression.

11.4. Psychological assistance to a family.

11.5. Suicide risk in palliative medicine.

11.6. «A syndrome of emotional burning out» at medical workers.

11.1. Behavioural and communicative skills in palliative medicine. Features of communication with patients, relatives of patients and colleagues in hospices, offices of the palliative help of versatile hospitals and oncological clinic, out of the health service organizations

The special attention is deserved by an approach to dying patients, behavior and tactics of the doctor with them. To diseases at which radical treatment is impossible, carry: malignant new growths in a terminal stage, HIV infection on AIDS stages, late stages of warm, nephritic, respiratory and hepatic insufficiency, a serious neuromuscular illness. In each phase of an illness patients keep hope of a favorable outcome. Many in panic to be afraid of death. It is necessary to remember that natural death − the phenomenon the extremely rare, the most part of people die of diseases, i.e. some kind of "illegal" death when the instinct of life is still kept and the organism combats an illness. Therefore never it is impossible to ascertain absolute hopelessness of a condition and there is no right to promote reduction of time of his life. However the incurable illness inevitably approaches reality of death.

− life priorities − are anew estimated lose value any trifles;

− there is a feeling release − what it would not be desirable to do does not become, i.e. lose force of obligation ("is obliged", it "is necessary", etc.);

− the momentary feeling of life amplifies;

− the importance of elementary vital events (change of seasons, a rain, a leaf fall, etc.) becomes aggravated;

− communication with favourite people becomes deeper;

− the fear to be rejected decreases, the desire to risk increases.

All these changes testify to increase in sensitivity of incurably sick person that makes concrete demands to those who is near it, − to relatives, doctors, psychologists. The patient has very important questions for it which it sets to people around. Whether one of such questions − «I will die soon?». There is no only a right answer on this question. Big responsibility in conversation with the patient about death is recommended. First of all it is quite good to advise to put to it in order vital affairs (the last desires, the will, etc.). It is possible not to say to the patient directly that, probably, he will soon die: «Everyone should be ready to the worst, especially the seriously ill patient». Some people are not inclined to think of completion of the terrestrial affairs because it seems to them that the solution of similar problems opens a death door. It is possible to discuss a fear problem with them before death.

Regularities in reaction to death. The sequence of reactions of incurably sick people on coming nearer death describes the ***Kubler-Ross model***:

1. *Denial*. At visit of different doctors patients first of all hope for diagnosis denial. The valid state of affairs disappears both from a family, and from itself. Denial gives the chance to see nonexistent chance, does the person blind to any signs of danger of death.

2. *Rage*. It is expressed by questions more often: «Why I?», «Why it happened with me?», «Why I was not heard by God?», etc.

3. *Compromise*. At this stage aspire to postpone as though a destiny sentence, changing the behavior, a way of life, refusing different pleasures, etc.

4. *Depression*. Having understood inevitability of the situation, gradually lose interest to world around, test grief, bitterness.

5. *Adaptation*. Humility is understood as readiness quietly to meet death.

Specific weight of separate stages at different people considerably differs. It should be noted that through all these stages there pass also members of the family, having learned about an incurable illness of the loved one.

How to behave with the dying patient? With dying, incurable patients it is especially difficult to work. Many doctors try to avoid them, give less attention, approach less often, less time talk on rounds.

1. It is impossible to consider fight lost. It is necessary to inspire to the patient hope the behavior and the relation to it, to pay attention to the slightest positive dynamics or a symptom.

2. Dying patients not always suffer from pain, is more often − from loneliness. Known philosophical saying: «The person always dies alone» quite often take too literally and justify them a protective isolation from the dying. But the fear of death and pain become even stronger if to leave the person of one. To dying it is impossible to treat as the already died. It is necessary for relatives to recommend to visit and communicate with it. It is not necessary to look on round at it compassionate, scared, guilty eyes, he is the same patient, as well as others. But the help not only medical, but also psychological is especially necessary to it. Dying it is not necessary to avoid, it is necessary to approach to it not less often and more often than to other patients, to ask usual questions of appetite, of departures, whether its bed to ask the sister all appointments as he transfers them are executed. To note any positive phenomena or absence of deterioration is simple, to encourage:« Unless I would give you so much time if you were hopeless?» All this calms the patient. Even if the patient is in a devocalization condition, it is necessary to examine, approach it to it.

3. It is necessary to listen attentively complaints dying and carefully to satisfy his requirements. Say some consoling words, explain to the patient that feelings had by it are absolutely normal.

4. Efforts of all people around should be directed on the benefit it people to the dying. In communication with it is necessary to avoid superficial optimism which causes suspiciousness and mistrust.

5. Dying people prefer to speak more, than to listen to visitors. Let's to them be uttered.

6. Speech dying often happens symbolical. For the best its understanding it is necessary to decipher sense of used symbols. Gestures of the patient, stories and memoirs which it shares are usually indicative. Quietly treat his anger.

7. It is not necessary to treat the dying person only as object of cares and sympathy. Quite often people around with the best intentions try to decide that it is better for dying. But excessive acceptance of responsibility reduces a range of independence of the patient by itself. It is necessary to listen to him, to allow it to participate in making decisions on treatment, visitors, etc.

8. The most bigger, than can use the dying person, − it is our personality. Certainly, we do not represent ideal means of the help, but

nevertheless best corresponding to this situation. Stay with the dying demands simple human responsiveness which we are obliged to show.

To the personnel working with dying and his relatives, the essential help too is necessary. With them first of all it is necessary to speak about the realized humility with feelings of fault and powerlessness. It is important to physicians to overcome humiliation of professional advantage. Such feeling quite often meets among doctors for whom the death of the patient in a sense is professional accident.

Special psychological problem is communication with relatives of patients. The psychology of relatives at contact to the doctor can be caused by their personal features, features of their former life, their actual relation to the patient. Quite often they can be more concerned a condition of the patient, than the patient. Their interest is concentrated only to that the patient as soon as possible recovered. Their data can be defined by conversations of their immediate environment, inconsistent data both on an illness, and on the medical personnel, the medical establishment, received at conversation with other visitors.

There can be strengthened "pressure" upon the doctor. Diligence of relatives can lead to creation of the wrong relations between the patient and the doctor. Relatives can show the discontent with the doctor, treatment at the patient, to say that the patient «will not transfer operation», «will not sustain such treatment», in the smallest details assort with the patient symptoms of his disease, "overfeed" patients, prevent to keep to a diet and treatment mode. Tactless relatives start to ask type questions «why you so look bad?» or «that with you made?», tell about the conflicts of the house or on work, fill up with problems and tasks from work. Quite often relatives make to the doctor the highest demands, without forgiving it the slightest mistake. Unfortunately it is frequent and the doctor does not wish to come into contact.

The doctor should notice and know relationship of the patient with relatives and as the last influence a condition of their patient. Sometimes it is necessary to limit communication with some relatives.

At contact of the doctor to relatives conversation should have purposeful character: to receive fuller and objective information on the patient and to make the relative the ally in fight against an illness. It is necessary to know that waits for the patient after a house extract. The leading role in relationship "doctor relative" should belong to the doctor.

Relatives should report only the most important and the checked data on the patient. Complexity of diagnostics, weight of a current quite often create negative psychological installation. To have to spend it is a lot of forces, time, patience, endurance to make them the adherents to provide to the patient necessary conditions for treatment and the subsequent correct medical and improving period. A problem "doctor relative" gains special value in case of death of the patient. To speak about it always it is difficult. It

is impossible to phone it, it is necessary to meet relatives, to spend for this certain time.

To death there should not be a professional accustoming.

11.2. The main recommendations and policy on rendering of medical care according to World Health Organization recommendations

Palliative medical care − is the approach, allowing to improve quality of life of patients (children and adults) and their families which have faced problems, connected with a life-threatening disease, a way of prevention and relief of sufferings at the expense of early identification, a careful assessment and treatment of pain and other physical symptoms, and also rendering of psychosocial and spiritual support.

Providing the palliative help is based on a principle of respect for decisions of patients and directed on rendering of practical support to members of their families, in particular, on grief overcoming in communications by loss of the loved one both on all extent of an illness, and in case of death of the patient.

Within national health systems the palliative help should be included in process of continuous rendering of medical care to people with life-threatening diseases. Thus it is necessary to create strategic communication between rendering of the palliative help and programs of prevention, early identification and treatment of these diseases. The palliative help should not be considered as a facultative type of therapy. It is necessary to provide services in rendering of the palliative help in parallel with attempts of radical treatment, adapting them for increasing physical, psychosocial and spiritual needs of patients, members of their families and the persons which are carrying out care of patients, in process of progressing of a disease and its transition to a terminal stage.

Services in rendering of palliative medical care should be provided according to principles of general coverage by the medical and sanitary help. Each person without an exception should have access to the complex of the main services established at national level in the field of strengthening of health, prevention, treatment, rehabilitation and the palliative help, and also to the main, safe, economically available, effective and qualitative medicinal and diagnostic remedies. Besides, the request for these services should not create financial difficulties, especially at representatives of needy and unprotected categories of the population.

Development and practical implementation given below measures of policy are an important condition for development of system of rendering of palliative medical care in a context of public health service:

1. the measures directed on integration of palliative medical care in activity of all levels of national health system with creation of necessary funding mechanisms.

2. the measures directed on strengthening and development of personnel resources of health service, including education and vocational training of medical workers with a view of ensuring appropriate reciprocal actions for satisfaction of requirement for the palliative help, and also a measure for preparation of volunteers and population education.

3. measures concerning the medicines, directed on ensuring availability of the main medicines necessary for treatment.

4. the measures directed on rendering of assistance to research activity with a view of carrying out an assessment of requirements for palliative medical care and development of effective standards and models of service, especially in the conditions of limitation of resources.

To number of measures which can promote expansion and strengthening of system of rendering of palliative medical care at country level, belong:

1. development and implementation at national level of the measures directed on inclusion of palliative medical care in process of continuous rendering of medical services to patients with life-threatening diseases at all levels of health system with special emphasis on services of primary medical and sanitary help and on the organization of rendering of the palliative help at level of local communities and at home;

2. information on questions of rendering of the palliative medical care, directed on assistance to achievement of general coverage by medical and sanitary service, to acceptance of political measures in the field of the main medicines with a support on results of an assessment of requirements for the palliative help, and also the measures directed on improvement of quality and safety of the palliative help;

3. implementation and monitoring of implementation of the recommendations offered in the Global plan of action on prevention of noninfectious diseases and fight against them for 2013-2020, and inclusion of provisions of this plan of action in national programs on ensuring general coverage with medical and sanitary service and availability of the main medicines;

4. inclusion in the training program of establishments of secondary medical education and educational institutions on preparation of nursing staff of questions of rendering of the palliative help (including its ethical aspects) and the organization within activities for development of personnel resources of health service of the corresponding preparation for providers of medical and sanitary services at all levels according to their functions and responsibility spheres;

5. ensuring appropriate access to the medicines being under control, with taking measures to counteraction to their illegal distribution and abuse of them by means of reduction of national and local standard and legal tools

in compliance with provisions of the management of WHO on national policy concerning the substances being under control;

6. ensuring granting all components of the palliative help (the main medical care and psychological and spiritual support of patients and members of their families) under control from the trained staff of health service if it is necessary;

7. development of the management devoted to ethical aspects of rendering of the palliative help, such as ensuring fair access to this type of the help, service with due respect for the patient and involvement of local community in process of development and realization of measures and programs;

8. partner interaction with other sectors with a view of development of research activity in the field of practice of rendering of palliative medical care, including development of profitable models of granting this type of service.

(Information on materials of the Report of the Secretariat of WHO, 134 Eve's session 134/28 from December 20, 2013, − «Strengthening of palliative medical care as one of components of complex treatment throughout all life cycle»).

11.3. Prevention of reactive depression

Depression (the lowered mood) − one of the most unpleasant emotional conditions of the personality which are often arising in various life experiences, and one of the most important symptoms of the majority of violations of mentality, and sometimes a dominating symptom (depressive neurosis, psychoses).

As a rule, the doctor usually faces so-called "reactive depression" which usually arises as reaction to the events injuring life (an incurable disease, and also the conflicts, intimate problems, various losses, including death of the loved one etc.). Reactive depression can be short-term (no more than 1 month) and prolonged (its duration from 1-2 months to 2 years) lasts. In process of progressing of a depression there are inadequate, logically groundless actions and acts, constant sense of guilt and decrease in self-image, loss of ability of concentration of attention, block fast power exhaustion. The late the depression, the failure is diagnosed, after all about 60 % of depressions come to an end with a suicide.

What it is not necessary to speak to the depressive patient? To inspire to the depressive patient that «everything will be good» and «it is not necessary to pay attention to trifles», i.e. in every possible way to encourage the patient rather harmfully, rather than it is useful. It only embitters the patient and aggravates a depression.

What it is necessary to remember in conversation with the depressive patient? First of all, it is necessary to establish, with what depression of a sort

we faced − manifestation of mental disease, with a neurotic depression or it is simple with normal reaction to sad events. The depression should not be confused to other violations. Sometimes the doctor takes depression symptoms for overfatigue, physical or mental exhaustion and recommends to the patient to have a rest, sleep, use more vitamins, to go to sanatorium, etc. However in case of a depression it helps a little.

The task the doctor in work with depressive patients is double: to support the patient and to help it with a psychological explanation of difficulties. The fact that the doctor is ready to "battle" to a depression, strengthens hope of the patient and will neutralize despair. Support and understanding reduce suffering and experience, help to restore self-esteem. The patient, seeing at least one person understanding and appreciating it, can change installation in relation to people around in the positive direction. With a view of restoration at the patient of belief in own possibilities it is necessary to pay attention to spheres of which it is competent, and his former achievements. It is important to mobilize aggressive motives of the patient that he could fight against vital tests more successfully.

The doctor should not wait (it frustrates the depressive patient even more and deepens a depression), and actively to talk to the patient about his experiences and external circumstances. Depressive patients demand bigger activity, than other contingent of patients. Better usual it is necessary to structure advisory conversation, especially in an initial stage. Similar tactics is caused by passivity of the patient, his unwillingness independently to analyze problems. If the doctor sits silently, he only will emphasize inability of the patient to adequate communication. Therefore at the beginning of conversation the expert bears the main responsibility for its contents.

In cases of a depression drugs treatment by energizers and psychotherapy sessions is usually used. Prescription of medicines and a dosage − this business of doctors, however the doctor should know, whether the patient of medicine and what force of their influence uses it. It is not necessary to give advice to the patient at the choice of drugs or the doses, however arising questions should be discussed with the doctor who has appointed medicine.

11.4. Psychological assistance to a family

The help to the sick patient is necessary, but psychological support of their relatives is not less important. If the loved one fell ill, the person will test the whole scale of feelings: pain, despair, powerlessness, rage, grief, grief, fatigue and even fault. Relatives and relatives of seriously ill people often should change the life, to be arranged under the changed situation. For example, to be discharged to look after from office the patient.

How to behave at a bed dying, as well as about what it is possible to talk to it how to pay visits to the patient, − doctor or the nurse who should

remember should teach it relatives and relatives that the family itself needs psychological support. The family of the dying person passes the same stages of a grief. It is necessary to prepare in advance psychologically for the forthcoming experiences of the family of the dying. The nurse should train relatives in elements of care of the dying patient at home and at first to help them with leaving (if necessary).

The doctor should explain to relatives of the patient that he should give the chance to continue to work, care of a family, to participate in solutions of the questions concerning him and his families as far as it is possible. The psychotherapist who will train in the correct communication with the relatives who have got to trouble will help.

The death often is a heavy shock for native and therefore to them in such cases it is necessary to treat with special care and attention. After death of the loved one of a consequence can be reflected in their mental balance and undermine health. Enduring loss of the loved one time and possibility are necessary for expression of the feelings. It is necessary to encourage and support conversations of relatives on the internal experiences. To lower a sharpness of reaction work with the psychologist or the psychotherapist will help.

11.5. Risk of a suicide in palliative medicine

The high suicide risk is connected with a variety of reasons, and from them strong mental trauma of the fact of establishment of an incurable disease is main. This diagnosis is often regarded by the patient as a sentence. As a result at many patients the depression develops. The person in a condition of a depression is inclined to self-damage in the obvious and hidden forms. Even the slight depression can outgrow in heavy with suicidal intentions. Without the qualified help the patient comes to thoughts on suicide and suicide commission. At incurably sick the suicide can be the considered and weighed decision. According to foreign researches the risk of suicide of oncological patients in 2-4 times is higher, than at healthy faces of the same age. Suicide attempt in 1-2 cases from the 3rd leads to death.

Suicide is considered awful, shameful business, and some doctors, working with depressive patients, involuntarily neglect such possibility and believe that their patients cannot even think of it. If the doctor shows a such blindness, there is a big danger to wellbeing and life of the patient. The problem consists, as a rule, not in concealment by the suicide of the intentions, and that it will not be heard when speaks about them.

How to define degree of risk of a suicide? There is an opinion that discussion with patients of possibility of suicide only strengthens their intentions. However, as a rule, conversation about the feelings pushing to suicide, reduces probability of realization of motives. Therefore the doctor should not evade from discussion with depressive patients of a problem of

suicide. Thereby it shows to the patient that thoughts on suicide can be apprehended and understood by other person.

Considering any intention of suicide is very serious, nevertheless it is impossible to forget about possibility of manipulative threat on purpose to convince the doctor of importance of the problem and to apply for a maximum of its time. The majority of simulators are hysterical persons. Some patients speak about suicide from desire to revenge that who allegedly loves them insufficiently. In general the element of hostility is present almost at each suicide.

Having met the depressive patient stating suicide intentions, it is very important to estimate risk of their realization. Life of the patient can depend on the correct forecast. The doctor can find out degree of probability of suicide, asking to the patient indirect questions. Directly to ask: «Whether you intend to commit suicide?» − it is unacceptable, because such question induces the patient to denial. Tactics of "gradual" inquiry is effective. Such course of poll gives the chance to learn more precisely how the patient in the thoughts on death far came.

What it is important to remember at consultation of potential suicide patients? It is necessary to estimate size of vital potential instead of probability of suicide and to ask the patient not about the reason of unwillingness to live, and about meaning of the life for it. The more is the threads connecting the patient with life, the suicide is less probable. There are certain rules of consultation of the persons, intending to commit suicide:

1. It is necessary to meet such patients more often.

2. The doctor should pay attention of the suicidal patient to positive aspects in his life. For example: «You mentioned that before in much were interested. Tell about the addictions» or «Always is for the sake of what to live. What do you think of it?». Such questions help the patient to find resources for overcoming of a difficult stage of life.

3. Having learned about intention of the patient to commit suicide, it is not necessary to panic, try to distract it any occupation and to resort to moralization («From it will change nothing», whether «You know, what all religions consider suicide by the greatest sin?»). Such tactics only will convince the patient that nobody understands it also the doctor - too.

4. The expert should employ with the patient between advisory meetings of significant people for it (relatives, friends).

5. The patient should have possibility at any time to call the doctor that that could supervise his emotional condition.

6. At high probability of suicide it is necessary to accept − to inform precautionary measures relatives of the patient, to discuss a question of hospitalization. It is not always easy to doctor to execute it. The patient quite often starts to deny the intentions and argues that there is nothing to worry for it. Nevertheless, it is better to doctor to count upon the intuition and to

consider dangerous signs in behavior of the patient as consolatory statements can have distracting character. In cases of obvious suicidal risk the doctor should demand immediate hospitalization though the majority of patients categorically protest against it. Possibly, each person, but a duty of the doctor in case of suicide threat − has the right of a final choice to make a maximum possible, to affect a choice of the patient for life.

7. The doctor should not allow to the patient to manipulate itself by means of suicide threat.

8. The doctor is obliged not to forget that he is not a God and, despite of the best motives, is not always capable to prevent suicide. The greatest responsibility for own actions is born by the patient. The doctor cannot completely and individually be responsible for the patient. It is only professionally responsible for suppression of realization of suicidal intentions. However the axiom − is incontestable if the patient really wants to commit suicide, nobody is capable to stop it. As note, «we tell "yes" lives of the patient, but should be ready to that some patients after all will tell the life "no".

9. The doctor is obliged to document, in writing, in detail the actions that in case of misfortune it could prove to itself(himself) and another that operated professionally and took all measures.

What features of communications with the patients, trying to make a suicide? Consultation of the patient goes on overcoming of motives to the suicide, which else remain after unfortunate attempt. Allocate three stages of consultation: in a sharp phase, in a phase of recovery and after recovery. Work of the doctor in the two first phases is especially significant.

Phase of the first contact after unfortunate suicide: into the forefront uniqueness of a situation and health of "loser suicide" act. The person who has tested the maximum tension of spiritual forces, understands that did not die, but the circumstances which have led to attempt to die, remained with it. "Awakening" moment − beginning of a new stage of life of this person. Therefore it is important, what "influence" will be entered in "blank sheet" of consciousness of the patient. Time of the first contact should not be limited, the patient should allow to be uttered. From the doctor meeting such patient, genuine sincerity, concentration and return of all the spiritual forces is required. Something means bigger, than a duty of the doctor. After suicide attempt the patient is most naked and very vulnerable, he clearly feels internal state of the doctor. In the first phase it is not necessary to begin discussion of the main conflict and only gradually it is possible to pass to the reasons and psychosomatic sense of suicide. Consultation should be directed on alarm and hopelessness reduction.

The phase of recovery begins, when the patient can come back to the former environment. During the second phase as, by the way, and after a complete recovery, repetition of suicidal motives is possible. Provoking

influence renders the environment which has been directly connected with an injuring factor. Therefore at the second stage work of the doctor w work with a family of the person which can potentially end the life suicide is very important. The help to a family quite often resolves problematic circumstances.

11.6. «A syndrome of emotional burning out» at medical workers

At doctors, nurses quite probably development of the psychological condition which has received the name «a syndrome of emotional burning out». It is characterized by emotional exhaustion, reduction or empathy loss, decrease in self-image and interest to life. Main reason − psychological, sincere overfatigue. Especially quickly and considerably it comes at excessive loading at people who as obliges should "give" to patients heat of the soul. Psychotherapists, teachers, doctors, social workers, i.e. professionals of communication appear "burning out" victims first of all. Young, inexperienced specialists and physically weakened persons are more subject to development of a syndrome of burning out.

«The syndrome of emotional combustion» is subjectively shown in feeling of mental exhaustion owing to what efficiency of professional interaction decreases: the doctor cannot be given completely to work anymore as it was before, self-image decreases, activity is subjectively perceived as insufficiently successful. Emergence of negative attitude to the patients perceived as a source of a chronic psychological scar is possible.

Cooperating with the patient, the doctor ceases to take into consideration the psychological phenomena connected with a disease - an internal picture of an illness of the patient with her difficult structure, being formed mechanisms of psychological protection, does not react to alarm of the patient, does not notice his depressive, suicide tendencies. In statements of the doctor about the patients there can be a cynicism, cold indifference and even hostility. This peculiar "crisis" of profession of a physician can repeat from time to time. Patients cease to address to the doctor for the help, sometimes preferring less skilled and competent, but more benevolent.

In similar crisis the doctor needs rest, activity change, psychological "unloading", participation in professional trainings or in the psychotherapeutic help. At the female doctors emotional exhaustion develops more than at the male doctors. "Burning down" describe as sympathizing, humane, soft, fond, inclined to idealize surrounding people. At the same time it persons emotionally unstable, with the mood swings, introverted, deprived of sufficient extent of emotional support.

Types of emotional burning out:

The first type − reduction of expressiveness of emotions when the sharpness of feelings and sweet of experiences disappears., It seems, everything is normal, but it is boring and simple on soul. Weakened feelings

to the dearest and close people. Even the favourite food became rough and fresh.

Second type − emergence of the conflicts to patients. At first they hidden. In a circle of the colleagues started to "burn out" the professional with neglect, and even with a jeer tells about some patients. Further he starts to feel hostility to them. At first it constrains it, then he hardly manages to hide the irritation, and, at last, there is an explosion and it splashes out from itself (himself) embitternment. Its victim, as a rule, becomes in anything not the guilty person who waited from the professional of the help or at least for participation.

The third type socially also is economically most dangerous to society, is characterized by loss of ideas of values of life, i.e. a condition in which «on everything to spit». It has a blank look. The world for it is indifferent.

Dynamics of «emotional burning out». At research of «a syndrome of emotional combustion» three phases were allocated:

The first − «tension phase». A harbinger and the mechanism starting «the syndrome of emotional combustion», is the fixed condition of disturbing tension against which are observed decrease in mood, irritability (a sign of weakening of control of emotional reactions and behavior as a whole) and reactions of depressive type.

Second phase − «resistance phase». This stage is connected with emergence of protective behavior on the nonparticipations type, aspirations to avoid influence of emotional factors and a tendency to restriction of own emotional reaction in reply to the most insignificant psychological scars. «The economy of emotions», restriction of emotional return simplifies and reduces communication process "doctor patient", introducing in it lines of superficiality and a formalism. The similar form of protection can be transferred out of limits of professional activity, reducing communication in all spheres of life that leads to a selectivity of interpersonal interaction.

The third phase − «an exhaustion phase» – is characterized by decrease in the power tone, the expressed psychovegetative violations. Decrease in mood with sense of hopelessness, the hopelessness, the raised level of alarm with signs of disorganization of mental activity (decrease in memory, violation of concentration of attention, etc.).

In process of experience accumulation the doctor is trained to "dose out" degree of an emotional involvement in the course of professional communication. Emotional "inclusiveness" is important at the beginning of communication with the patient, at establishment of psychological contact. In further interaction emotional components of communication can be considerably reduced. Intensity of emotional contacts to the patient raises only at separate, most significant stages of diagnostics and therapy: if

necessary to convince the patient to undergo painful diagnostic procedure, in case of making decision on carrying out operation, especially, if there is a probability of a failure. The role of emotional interaction increases in situations of emergence of threat of life of the patient, at communication with the depressive patients having suicide tendencies, and also at contacts to the patients who have suffered a heavy mental trauma (death of the loved one, disability, divorce).

Prevention of «emotional burning out». "Burning out" usually manages to be avoided, if the collective and a family support in the person conviction that, despite difficult living conditions and works, it can adequately prove. But the main thing − physical and sincere rest is necessary for "burning out".

As effective measure of prevention of a stress and burning out creation of the correct organizational structure serves:

1. To provide a cooperation of two professionals (more skilled and less skilled or equal by experience), medical workers, giving particular attention to those parties of work which cause the greatest difficulties.

2. To create feedback system from the lowest link to the highest and on the contrary (for example, regularly to give talks with employees of rather arising problems and to give feedback concerning efficiency of their work).

3. To watch level of the tension arising at employees and to undertake necessary measures when tension becomes excessive.

4. To reduce the requirements, which workers show to themselves, by encouragement of statement of more realistic and attainable aims.

5. To provide training and professional development possibility for the purpose of overall performance growth.

6. To train in strategy of fight against a stress.

7. To create in collective of the friendly atmosphere of mutual understanding.

References:

1. Азбука коммуникации в сфере здравоохранения методические рекомендации для специалистов, занимающихся коммуникацией в здравоохранении, 2010 / Под ред.: Туула Копонен; соавт.: А. Партанен, Л. Белая, Д. Трофимова, Ю. Веселова. – Йоэнсуу-Петрозаводск, 2010. – 32 с.

2. Биомедицинская этика: Практикум. Уч. пособие / Под общ. ред. С.Д. Денисова, Я.С. Яскевич. – Мн.: БГМУ, 2011.

3. Бориснев С. В. Социология коммуникации: Учеб. пособие для вузов. − М.: ЮНИТИ-ДАНА, 2003.− 270 с.

4. Королева, Е.Г. Деонтология в психиатрии. Учебно-методическое пособие / Е.Г. Королева − Гродно: УО «ГрГМУ», 2009. − 99 с.

5. Основы биоэтики. Уч. пособие / Под ред. Я.С. Яскевич, С.Д. Денисова. – Мн.: Вышэйшая школа, 2009. – 351 с.
6. Психология коммуникации: курс лекций / С.В. Кручинин. – Минск: Современные знания, 2009. - 115 с.
7. Сурмач, М.Ю. Коммуникационный процесс врач - пациент в современном здравоохранении / М.Ю. Сурмач, Е.М. Тищенко // Журнал Гродненского государственного медицинского университета. − 2007. − № 1. − С. 198 - 201.
8. Формирование коммуникативной компетентности у студентов медицинского ВУЗА (теоретические и практические аспекты). Уч.-метод. пособие / Под ред. Ю.В. Михайлюк, В.А. Хриптович, В.А. Манулик – Мн.: БГМУ, 2015.

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BIOMEDICAL ETHICS AND COMMUNICATIONS IN HEALTH SERVICE

учебно-методическое пособие
на английском языке

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